No. 86-1764-CFX
Status: GRANTED

Title: Bethesda Hospital Association, et al., Petitioners
v.
Otis R. Bowen, Secretary of Health and Human Services

Docketed:
May 2, 1987

Court: United States Court of Appeals
for the Sixth Circuit

See also:
87-443

Counsel for petitioner: Hedlund,Carel T

Counsel for respondent: Solicitor General

Entry	Date	Note	Proceedings and Orders
1	May 2 1987	G	Petition for writ of certiorari filed.
2	May 14 1987	N	Motion of petitioners to defer consideration of the petition filed.
4	Jun 5 1987		Order extending time to file response to petition until July 4, 1987.
5	Jul 3 1987		Order further extending time to file response to petition until August 3, 1987.
6	Aug 5 1987		Order further extending time to file response to petition until August 17, 1987.
7	Aug 17 1987		Brief of respondent Bowen, Sec., HHS in opposition filed.
8	Aug 19 1987		DISTRIBUTED. September 28, 1987
9	Sep 18 1987	X	Supplemental brief of petitioners Bethesda Hosp. Assn., et al. filed.
10	Oct 5 1987		Petition GRANTED.
			**********
11	Nov 19 1987		Brief of petitioners Bethesda Hosp. Assn., et al. filed.
13	Nov 19 1987		Brief amicus curiae of American Hospital Assn. filed.
14	Nov 19 1987		Joint appendix filed.
12	Nov 23 1987		Record filed.
		*	Certified copy of proceedings and appendix received.
15	Dec 1 1987		Record filed.
		*	Certified copy of original record, box, received.
17	Dec 9 1987		Order extending time to file brief of respondent on the merits until December 31, 1987.
18	Dec 30 1987		Order further extending time to file brief of respondent on the merits until January 8, 1988.
19	Jan 5 1988		SET FOR ARGUMENT. Monday, February 29, 1988. (3rd Case). (1 hour).
20	Jan 8 1988		Brief of respondent Bowen, Sec., HHS filed.
21	Jan 14 1988		CIRCULATED.
22	Feb 8 1988	X	Reply brief of petitioners Bethesda Hosp. Assn., et al. filed.
23	Feb 29 1988		ARGUED.

No. 86 1764

Supreme Court, U.S.
FILED
MAY 2 1987
JOSEPH F. SPANIOL, JR.

In the Supreme Court of the United States

OCTOBER TERM, 1986

BETHESDA HOSPITAL ASSOCIATION AND
THE DEACONESS HOSPITAL OF CINCINNATI, OHIO,
PETITIONERS,

v.

OTIS R. BOWEN, M.D., SECRETARY
OF HEALTH AND HUMAN SERVICES,
RESPONDENT.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTION PRESENTED FOR REVIEW

A Medicare provider (*e.g.*, a hospital) must file a cost report with its fiscal intermediary at the end of each year. The fiscal intermediary audits the cost report and issues a Notice of Program Reimbursement (NPR) indicating the total amount of Medicare reimbursement due the provider for the year. A provider may appeal to the Provider Reimbursement Review Board if it is dissatisfied with the amount of reimbursement as indicated in its NPR. The Secretary has interpreted the Medicare statute to require that, in order for a provider to challenge one of the Medicare regulations, the provider must claim costs expressly stated to be non-allowable under that regulation when filing its cost report.

The question presented for review, as to which the Courts of Appeal are in conflict, is:

Whether the Secretary's informal interpretation described above can be the basis for denying a provider access to the administrative and judicial process where: (1) the Medicare statute on its face does not impose such a requirement; (2) neither the statute nor the regulations provide notice that filing a cost report in compliance with the regulations operates as a waiver of any right to be heard; and (3) the intermediary cannot invalidate the regulation in order to allow the costs?

A necessary subquestion is whether the courts' construction of the Medicare statute to deny a right to be heard under such circumstances is contrary to the presumption favoring judicial review as enunciated in *Bowen v. Michigan Academy of Family Physicians,* 106 S.Ct. 2133 (1986)?

LIST OF PARTIES AND RULE 28.1 LIST

The parties to the proceedings below were the petitioners Bethesda Hospital Association and The Deaconess Hospital of Cincinnati, Ohio, and the respondent Otis R. Bowen, M.D., Secretary of Health and Human Services.

The following Ohio hospitals were also plaintiffs-appellees in the proceedings below: Bethesda Hospitals, Inc. of Cincinnati; Brown County General Hospital; Clinton Memorial Hospital; Doctors Hospital, Inc.; Doctors Hospital of Nelsonville; Good Samaritan Medical Center; Grady Memorial Hospital; Guernsey Memorial Hospital; Kettering Medical Center; Lancaster-Fairfield Community Hospital; Madison County Hospital, Inc.; East Ohio Regional Hospital, Inc. d/b/a Martins Ferry Hospital; Medical Center Hospital; Memorial Hospital of Union County; The Mercy Hospital Corporation; Mercy Memorial Hospital of Urbana, Ohio, Inc.; Miami Valley Hospital; Ohio State University Hospitals; Our Lady of Mercy Hospital of Mariemont; Pike Health Services, Inc., d/b/a Pike Community Hospital; Riverside United Methodist Hospital; St. Ann's Hospital of Columbus, Inc.; St. John Medical Center; Sycamore Medical Center; and Shelby County Memorial Hospital Association, d/b/a Wilson Memorial Hospital. Because these hospitals are not affected by the jurisdictional issue presented for review, they are not named as parties herein.

The parent company of petitioner Bethesda Hospital Association is Care One Health Systems, Zanesville, Ohio.

The parent company of petitioner The Deaconess Hospital of Cincinnati, Ohio is The Deaconess Associates, Inc., Cincinnati, Ohio.

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No.

In the Supreme Court of the United States

OCTOBER TERM, 1986

BETHESDA HOSPITAL ASSOCIATION AND
THE DEACONESS HOSPITAL OF CINCINNATI, OHIO,
PETITIONERS,

v.

OTIS R. BOWEN, M.D., SECRETARY
OF HEALTH AND HUMAN SERVICES,
RESPONDENT.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The petitioners Bethesda Hospital Association and The Deaconess Hospital of Cincinnati, Ohio respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Sixth Circuit, entered in the above proceeding on February 2, 1987.

OPINIONS BELOW

The opinion of the Court of Appeals for the Sixth Circuit is reported at 810 F.2d 558, and is reprinted in the appendix hereto, p. 1a, *infra*. The decision in ***Baptist Hospital East v. Secretary of HHS***, 802 F.2d 860 (6th Cir. 1986), by which the court below was bound, is reprinted in the appendix hereto, p. 10a, *infra*.

The memorandum decision of the United States District Court for the Southern District of Ohio (Spiegel, D.J.) is reported at 609 F.Supp. 1360, and is reprinted in the appendix hereto, p. 29a, *infra*.

The decision of the Provider Reimbursement Review Board is reprinted in the appendix hereto, p. 52a, *infra*.

JURISDICTION

The judgment of the Court of Appeals for the Sixth Circuit sought to be reviewed was issued and entered on February 2, 1987. The judgment was amended by an order entered February 25, 1987. App., p. 9a.

The due date for a petition for rehearing *en banc* was Monday, February 16, 1987, the Washington's Birthday holiday. Because February 16, 1987 was a legal holiday, and in the absence of a published local rule to the contrary, petitioners followed Rule 26(a) of the Federal Rules of Appellate Procedure (entitled "Computation of Time") and filed their petition for rehearing *en banc* on February 17, 1987, the day following Washington's Birthday. The petition was denied as untimely by one day by order dated March 16, 1987. Petitioners' motion for reconsideration of the March 16, 1987 order was denied by order filed April 8, 1987.

The jurisdiction of this Court to review the judgment of the Sixth Circuit is invoked under 28 U.S.C. § 1254(1).

STATUTE INVOLVED

42 U.S.C. § 1395oo. Provider Reimbursement Review Board.

> (a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and

> which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or
>
> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,
>
> (B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or
>
> (C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,
>
> (2) the amount in controversy is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.
>
> * * *

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

* * *

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board or any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing,

such provider may file a request for a determination in writing by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

* * *

STATEMENT OF THE CASE

The petitioners are hospitals which are providers of inpatient hospital services to Medicare beneficiaries, pursuant to a "provider agreement" with the Secretary of

Health and Human Services ("Secretary"). At the end of each cost year, a provider must submit its cost report to its Medicare fiscal intermediary, which is generally a private insurance company that has a contract with the Secretary. The fiscal intermediary reviews and audits the cost report, and issues a Notice of Program Reimbursement (NPR) indicating the total amount of Medicare reimbursement due. In doing so, the intermediary is bound by the Medicare regulations and cannot allow costs in excess of those permitted under the regulations. If a provider is dissatisfied with the amount of reimbursement it receives, and the amount in controversy is $10,000 or more, it may file an appeal with the Provider Reimbursement Review Board ("Board").

The petitioners, together with 25 other Ohio hospital Medicare providers, filed a group appeal with the Board pursuant to 42 U.S.C. § 1395oo(a). The appeal challenged the validity of a Medicare regulation promulgated by the Secretary ("the 1979 Malpractice Rule", codified at 42 C.F.R. § 405.452(a)(1)(ii)(1984)) which drastically altered the method by which Medicare reimbursed providers for their malpractice insurance costs. With respect to all the other providers in the group appeal, the Board determined that it did not have authority to invalidate the regulation and granted expedited review pursuant to 42 U.S.C. § 1395oo(f)(1). This permitted the providers to file their challenge to the 1979 Malpractice Rule directly in district court.

However, with respect to the two petitioners, the Board determined that it did not have jurisdiction to hear their claims and dismissed their appeals. The petitioners had filed their cost reports in compliance with the 1979 Malpractice Rule, thus "self-disallowing" their claims for reimbursement of costs in excess of those allowed under the Rule. Neither the statute, the regulations nor any instructions require that a provider must violate a regulation and claim costs not permitted under that regulation in

order to preserve its appeal rights. Nevertheless, the Board held that it did not have jurisdiction to hear the "self-disallowances", because the petitioners had not claimed the costs in excess of those allowed under the 1979 Malpractice Rule on their cost reports, and therefore the fiscal intermediary had not disallowed the costs before issuing the NPR. App., p. 54a-57a.

The petitioners appealed the Board's denial of jurisdiction to the district court, pursuant to 42 U.S.C. § 1395oo(f)(1). The district court reversed the decision of the Board, finding that the plain language of § 1395oo(d), which authorizes the Board "to make any other revisions on matters covered by [the] cost report even though such matters were not considered by the intermediary in making such final determinations," gives the Board jurisdiction to hear self-disallowed claims, despite the fact the intermediary did not first deny such claims. App., p. 34a. The district court also held that the doctrine of exhaustion of administrative remedies does not support the Secretary's position that claims must first be presented to the intermediary, because the intermediary is bound by the Secretary's regulations and therefore cannot grant the relief the petitioners seek, i.e., invalidation of the 1979 Malpractice Rule. App., p. 39a-41a.

The court of appeals reversed the decision of the district court on the self-disallowance issue because it was bound by the previous decision of another panel of the Sixth Circuit in *Baptist Hospital East v. Secretary of HHS*, 802 F.2d 860 (6th Cir. 1986). App., p. 5a-6a. The panel in *Baptist Hospital East* found that where a provider complies with the Secretary's regulation in completing its cost report and effects a self-disallowance, it has disclaimed entitlement to reimbursement for costs in excess of those allowed under the regulations. App., p. 14a-16a. The *Baptist Hospital East* panel adopted the analysis of the Court of Appeals for the D.C. Circuit in *Athens Community Hospital, Inc. v. Schweiker*, 686 F.2d 989 (D.C. Cir. 1982)

(*Athens I*), *modified, Athens Community Hospital, Inc. v. Heckler,* 743 F.2d 1 (D.C. Cir. 1984) (*Athens II*). *Athens II* held that in order for the Board to have jurisdiction over a provider's appeal, a provider must present a claim for reimbursement or otherwise notify the intermediary of its dispute before the intermediary issues the NPR.

The court of appeals in the instant case rejected the petitioners' argument that this Court's decision in *Bowen v. Michigan Academy of Family Physicians,* 106 S.Ct. 2133 (1986) required that the statutory provision governing administrative and judicial review be construed in accordance with the presumption favoring judicial review. App., p. 6a. However, the court continued, "[w]ere we considering this [self-disallowance] issue as a matter of first impression, we may well have reached a different conclusion as to the advisability of requiring submission of statutory and/or constitutional challenges to a private insurance company as a condition precedent to further administrative as well as judicial review of the Secretary's regulations." App., p. 7a. As indicated in the jurisdiction section above, the court denied the petitioners' petition for rehearing *en banc.*

REASONS FOR GRANTING THE WRIT

I. A CONFLICT AMONG CIRCUIT COURTS OF APPEALS EXISTS AS TO THE PROPER INTERPRETATION OF THE MEDICARE JURISDICTIONAL STATUTE

A. *Primary Conflict*

Six courts of appeals have addressed the question whether, under § 1395oo, the Provider Reimbursement Review Board has jurisdiction to hear self-disallowed claims. To date, three different and distinct answers have been given to the question.

The Seventh Circuit, in *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services,* 698 F.2d 1337 (7th Cir.), *cert. denied,* 464 U.S. 830 (1983),

held that the Board does have jurisdiction to hear self-disallowed claims. The court found that the language of § 1395oo(d) "vests broad authority" in the Board, and concluded that "since the statute allows the Board to consider matters outside of the cost reports," 698 F.2d at 1346, the Board can hear self-disallowances.

The District of Columbia Circuit, in *Athens II,* reached the contrary conclusion. The court found that the language of § 1395oo(d) creates two separate and independent grants of jurisdiction: 1) to review decisions made by the fiscal intermediary and 2) to make any other revisions. 743 F.2d at 4. However, the court went on to conclude that the second grant can only be exercised if necessary to accommodate any decisions made under the first grant of power, and does not give the Board independent authority to hear self-disallowances. 743 F.2d at 9. Central to the court's rationale was the notion that the intermediary's analysis and conclusions on the claims are essential to the Board's determination. 743 F.2d at 6-7. The Sixth Circuit in *Baptist Hospital East,* the Fourth Circuit in *Community Hospital of Roanoke Valley v. Health and Human Services,* 770 F.2d. 1257 (4th Cir. 1985), and the Eleventh Circuit in *North Broward Hospital District v. Bowen,* 808 F.2d 1405 (11th Cir. 1987), essentially adopted the *Athens* decision and held that the Board cannot hear self-disallowed claims.

Most recently, the First Circuit arrived at yet a third reading of the statutory language. In *St. Luke's Hospital v. Secretary of Health and Human Services,* 810 F.2d 325 (1st Cir. 1987), the court held that the language of § 1395oo(d) is clear and unambiguous in giving the Board the power to hear all "matters covered by [the] cost report", including self-disallowed claims. But the court went on to hold that this power is discretionary, and that it is up to the Board whether that power should be exercised in a given case.

The result of this three-way split among the circuits is that whether the Board will hear self-disallowed claims not raised with the intermediary as a contested claim prior to issuance of the NPR now depends on where the provider is located. If it is located in the Seventh Circuit, the answer is yes; if in the District of Columbia, the Fourth, Sixth or Eleventh Circuits, the answer is no; if in the First Circuit, the answer is maybe. District Courts outside these circuits have similarly split. *See, e.g., Metropolitan Medical Center and Extended Care Facility v. Heckler,* No. 3-84-411 (D. Minn. June 7, 1985) *reprinted in* Medicare and Medicaid Guide (CCH) ¶34,887 (no jurisdiction over self-disallowed costs); *Adams House Health Care v. Heckler,* 604 F. Supp. 110 (N.D. Cal. 1984), *appeal pending,* No. 85-1512 (9th Cir.) (jurisdiction exists over self-disallowed costs).

B. *Secondary Conflict*

A secondary conflict between the circuits involves whether the presumption favoring judicial review, recognized by this court in *Abbott Laboratories v. Gardner,* 387 U.S. 136, 141 (1967) and affirmed in the Medicare context in *Bowen v. Michigan Academy of Family Physicians,* 106 S. Ct. 2133 (1986), applies to the interpretation of statutory provisions setting forth the administrative and judicial review process. The Eleventh Circuit in *Memorial Hospital v. Heckler,* 706 F.2d 1130 (11th Cir. 1983), applied the presumption to interpret 42 U.S.C. § 1395oo(g), part of the statute governing administrative appeals to the Board. Subsection 1395oo(g) provides:

> The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

The Eleventh Circuit held that where a provider seeks to challenge a regulation that defines which items are "personal comfort items" excluded from coverage under Section 1395y, administrative and judicial review is not precluded by subsection 1395oo(g). "Such a result would run contrary to the presumption favoring judicial review." 706 F.2d at 1133.

In contrast, the Sixth Circuit in the case below refused to apply the presumption favoring review to interpret the statutory provisions of § 1395oo governing appeals to the Board. The court held that the presumption favoring judicial review is applicable only where Congress has not provided a review mechanism, and that it does not apply to the interpretation of a statutory scheme for review. App., p. 5a-6a. This position is in conflict with that taken by the Eleventh Circuit.

The granting of this petition will achieve a uniform construction of the statutory language, assist the Secretary in the administration of the Medicare program, and ensure that all Medicare providers will understand what the statute requires.

II. THE DECISION BELOW CONFLICTS WITH A PREVIOUS DECISION OF THIS COURT.

In *Bowen v. Michigan Academy of Family Physicians,* 106 S.Ct. 2133 (1986), this Court emphatically affirmed the strong presumption favoring judicial review of agency actions in the Medicare context. Citing the legislative history of the Administrative Procedure Act, the Court acknowledged that only upon a clear and convincing showing of legislative intent to restrict access to review may those aggrieved by agency action be denied judicial review of their claims. 106 S.Ct. at 2136.

The effect of the interpretation given the Medicare statute by the court below is to deprive the petitioners of their right to an administrative and judicial review of their

challenge to the Secretary's regulation, despite the fact that they have met all the express requirements Congress specified in § 1395oo(a) for entitlement to such a hearing (*i.e.*, they filed cost reports, they are dissatisfied with the amounts of their NPRs, they appealed to the Board within 180 days, and the amounts in controversy exceed $10,000). Where Congress has not expressly stated that a dispute must first be raised with the intermediary as a prerequisite for entering the administrative appeals process, the reading of such a restrictive requirement into the statutory language is contrary to interpreting a remedial statute in accordance with the presumption favoring judicial review. Such a reading is inconsistent with *Michigan Academy*.

III. THIS ISSUE INVOLVES THE REQUISITE PUBLIC IMPORTANCE TO MEDICARE PROVIDERS THROUGHOUT THE NATION.

The question whether the Board has jurisdiction to hear self-disallowed claims affects all types of Medicare providers throughout the country that seek access to the administrative and judicial review process through the Provider Reimbursement Review Board. These providers include hospitals, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities.

For hospitals, this issue continues to be important even with the advent of the Medicare prospective payment system (PPS) (effective October 1, 1983), under which hospitals receive a fixed amount per Medicare discharge, depending on the patient's diagnosis. First, those hospitals exempt from PPS (*e.g.*, children's hospitals, psychiatric hospitals) still receive cost reimbursement on the basis of their filed cost reports, and all their costs are subject to appeal to the Board. Second, those hospitals covered by PPS receive, for the first four years, interim rates based in part on a cost report filed in an earlier "base year," generally fiscal year 1982. Disputes concerning the base year cost

report (including the self-disallowance issue) are still in the administrative and judicial review process, and the result of those appeals will affect the hospitals' PPS rates. And third, these PPS hospitals continue to receive reimbursement for certain costs on a cost basis, which depends on the filing of cost reports in each PPS year. The self-disallowance issue can arise in any of these years.

In addition, all non-hospital providers are cost-reimbursed based on filed cost reports, and are entitled to appeal their cost reimbursement disputes to the Board. The self-disallowance issue can arise in any of these appeals.

Many of these providers in good faith complete their cost reports in accordance with the Secretary's regulations, even if they disagree with those regulations, unaware that such compliance may be deemed a waiver of their rights to challenge the validity of those regulations. Inasmuch as the Secretary's interpretation of the statute with respect to self-disallowances has never been promulgated as a regulation, the providers do not have notice of the Secretary's position.

Just as the Internal Revenue Service depends upon voluntary compliance with regulations by taxpayers, so does the Medicare program depend upon voluntary compliance with regulations by providers completing the complex Medicare cost report forms (over one-half inch thick when completed with accompanying worksheets). Yet the Secretary's interpretation requires providers to violate the regulations in order to preserve their appeal rights. This position undermines the goal of good-faith compliance by providers, and effective administration of the Medicare program.

CONCLUSION

For the foregoing reasons, this petition for a writ of certiorari should be granted.

Respectfully submitted,

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United States Court of Appeals For the Sixth Circuit

No. 86-3090

BETHESDA HOSPITAL, ET AL.,
Plaintiffs-Appellees,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,
Defendant-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF OHIO.

Decided and Filed February 2, 1987

Before: KEITH and GUY, Circuit Judges; and EDGAR, District Judge.*

GUY, Circuit Judge. Plaintiffs, a group of twenty-nine hospitals which are providers of services under the Medicare Act, challenged in the district court the promulgation of the 1979 Malpractice Rule by the Secretary of Health and Human Services. In addition, two of the hospitals contested a decision by the Provider Reimbursement Review Board (PRRB) that it lacked jurisdiction to review their claims because those claims were not properly raised in their cost reports filed with the fiscal intermediary. The following issues were presented to the district court:

> 1) Whether the Provider Reimbursement Review Board (PRRB) erred in concluding that it lacked jurisdiction over the claims of plaintiffs who self-

*Honorable R. Allan Edgar, United States District Court, for the Eastern District of Tennessee, sitting by designation.

disallowed malpractice insurance costs? 2) Is the challenged regulation invalid under the Administrative Procedure Act (APA) because of deficiencies in either the Notice of Proposed Rule Making or the Basis and Purpose statement accompanying the regulation in final form? 3) Is the challenged regulation violative of the APA as arbitrary and capricious, an abuse of discretion or otherwise not in accordance with law? 4) Is the challenged regulation invalid because it is inconsistent with the Medicare Act?

609 F. Supp. 1360, 1363 (S.D. Ohio 1985).

After review of the administrative record and filings by counsel, the district court concluded that:

> 1) The PRRB erred in concluding that it lacked jurisdiction over the claims of the health care providers who "self-disallowed" the malpractice insurance costs; 2) the challenged regulation is violative of the APA in two respects: a) the regulation in final form was not accompanied by an adequate statement of basis and purpose; and b) the issuance of the regulation, based upon the data on which the Secretary relied, was arbitrary and capricious. We do not rule on the issue of whether the challenged regulation is invalid because of alleged inconsistency with the Medicare Act.

Id.

Based on these conclusions, the court granted the plaintiff-hospitals' (the hospitals) motion for summary judgment and ordered further briefing on the issue of the appropriate relief. On November 25, 1985, the court issued an order remanding the case to the Secretary for the purpose of granting judgment to the hospitals in the amount of $2,965,767.00 plus interest. The court specifically declined to remand the case to the Secretary for application of any retroactive rulemaking which might

result from the Notice of Proposed Rulemaking published by the Secretary on June 17, 1985. 50 Fed. Reg. 25,178. The Secretary timely appealed this order of remand and argues the following issues on appeal:

> 1. Whether, in light of the promulgation of the 1986 Malpractice Rule on April 1, 1986 (51 Fed. Reg. 11,142, appearing at 42 C.F.R. § 413.56),[1] this case is now moot and the district court's decision should thus be vacated and the complaint dismissed.
>
> 2. Assuming *arguendo* that the case is not technically moot, whether the appropriate relief is to remand this case to the district court with instructions to remand to the Secretary for application of 42 C.F.R. § 413.56 to the cost years in plaintiffs' complaint.
>
> 3. Whether the district court erred in concluding that the Provider Reimbursement Review Board (PRRB) should have exercised jurisdiction over the claims of plaintiffs Bethesda Hospital and Deaconess Hospital.

For the reason below, the decision of the district court is affirmed in part and reversed in part.

I.

With respect to the first two issues on appeal, the Secretary argues that the 1986 Rule, promulgated subsequent to the district court decision in this case, automatically supercedes the invalidated 1979 Rule since, by its terms, it applies to cost reporting periods beginning July 1, 1979. Therefore he contends that, since the 1986 Rule has not yet been applied to the hospitals' cost reports

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[1] The Secretary has advised the court that the interim final rule, originally to be codified at 42 C.F.R. § 405.457, has been redesignated as 42 C.F.R. § 413.56. *See* 51 Fed. Reg. 34,790 and 34,808-09 (September 30, 1986).

for the contested years (1980 and 1981), there is no "final decision" of the PRRB, a prerequisite to federal court jurisdiction. He argues that, since the 1986 Rule automatically supplants the invalid 1979 Rule and governs the cost years in question, there is no longer a "live controversy" between the parties or, in the alternative, that the case must be remanded to the PRRB for issuance of a final decision pursuant to the *1986 Rule* before the court can properly entertain jurisdiction over the hospitals' claims.

In so arguing, the Secretary ignores Supreme Court authority stating that a dispute involving a monetary judgment constitutes a concrete interest in the outcome of the litigation and precludes a finding of mootness based on subsequent events. *Ellis Brotherhood of Railway, Airline and Steamship Clerks,* 466 U.S. 435 (1984); *New York City Transit Authority v. Beazer,* 440 U.S. 568, 580-81 (1979) ("the case is not moot since their claims arose even before the Act itself was passed, and they have been awarded monetary relief"). Further, the Secretary's argument presumes that it is the agency's sole province to determine the issue of retroactivity. This precise issue arose and has been decided by this court in our opinion in *Mason Hospitals v. Bowen,* No. 86-1011, where we held that the Secretary is prohibited from applying the 1986 Rule retroactively to 1979. Since our decision in that case is dispositive of the first two issues on appeal here, we hereby adopt the rationale expressed in *Mason* with reference to the twenty-seven hospitals in this case whose right to contest the retroactive effect of the 1986 Rule is undisputed.

II.

The only issue remaining is the jurisdictional one involving Bethesda and Deaconess Hospitals. The factual background relative to this issue follows.

Twenty-seven of the plaintiff-hospitals notified the fiscal intermediary at the time they filed their cost reports for 1980 and 1981 that they disputed the validity of the 1979 Malpractice Rule and its application to their claims for malpractice premium reimbursement. However, both Bethesda and Deaconess Hospitals complied with the 1979 Rule by completing and attaching Schedule D-8 to their cost reports, "Apportionment of Malpractice Insurance Costs." Schedule D-8 required hospitals to list their total malpractice insurance costs and then apply the methodology of the 1979 malpractice regulation in determining allowable Medicare costs.

The hospitals' cost reports thus included a claim for reimbursement for malpractice insurance costs, but completion of Schedule D-8 thus effectuated a "self-disallowance" of such malpractice insurance costs in excess of those allowed under the 1979 Rule. Because these hospitals complied with the Secretary's regulation and cost report instructions, there was no need for the fiscal intermediary reviewing their cost reports to make an audit adjustment with respect to the malpractice insurance issue before issuing a Notice of Program Reimbursement.

These hospitals timely filed requests for a hearing with the PRRB, seeking reimbursement for malpractice insurance costs under the pre-1979 utilization methodology. The PRRB determined that it was without jurisdiction over the claims of Bethesda and Deaconess Hospitals because they had failed to adequately present a "claim" for their premium reimbursements sufficient to notify the intermediary of a "dispute" as to this cost item.

In *Bapist Hospital East v. Secretary of HHS,* 802 F.2d 860 (6th Cir. 1986), this precise issue was addressed by another panel of this court. Following the rationale of the District of Columbia Circuit in *Athens Community Hospital, Inc. v. Schweiker,* 743 F.2d 1 (D.C. Cir. 1984) (Athens II), we held that the PRRB had properly refused

to exercise jurisdiction over those claims by providers who had self-disallowed reimbursement and had failed to challenge the Secretary's regulations before the fiscal intermediary. *See also University of Cincinnati v. Heckler*, No. 85-3651 (6th Cir. 1986) (reaching the same conclusion). At oral argument before the panel, counsel for the hospitals raised the argument that the Supreme Court's recent decision in *Bowen v. Michigan Academy of Family Physicians*, 106 S. Ct. 2133 (1986), wherein the Court emphatically upheld the presumption of reviewability of agency determinations, requires us to review our holding in *Baptist Hospital*.

Michigan Academy dealt with a challenge to the validity of a regulation promulgated under Part B of the Medicare Program, which provides reimbursement to physicians and other individuals who render services to covered participants. The question presented in that case was whether Congress intended to entirely bar judicial review of amount determinations under Part B by enactment of 42 U.S.C. §§ 1395ff, 1395ii, and 1395u. Despite the government's contention to the contrary, the Court held that these statutes foreclosed judicial review of only particular, individualized *amount* determinations but not challenges to the *method* by which such determinations were made.[2]

We find *Michigan Academy* inapposite to the issue presented in the case at bar. That case dealt only with the right to judicial review in the absence of meaningful administrative review procedures and in view of 42 U.S.C.

[2] "In light of Congress' express provison for carrier review of millions of what it characterized as 'trivial' claims, it is implausible to think it intended that there be *no* forum to adjudicate statutory and constitutional challenges to regulations promulgated by the Secretary." *Michigan Academy*, 106 S. Ct. at 2140 (emphasis in original).

§ 405(h),[3] which has been construed to confine judicial review to those cases which have exhausted available administrative remedies. Title 42, U.S.C. § 1395oo clearly establishes a scheme of administrative review of providers' disputes via the PRRB, and we deal here with statutory interpretation of that section and the proper scope of the PRRB's function and not with a situation in which no scheme of administrative review is provided and the Secretary is attempting to foreclose judicial review as well. Since provider appeals proceed under an established system of administrative review, our holding in *Baptist Hosptial* was essentially one which defined the *steps* in that process to include submission of a "claim" before the fiscal intermediary as a prerequisite to PRRB and judicial review, in essence an exhaustion requirement.

Were we considering this issue as a mater of first impression, we may well have reached a different conclusion as to the advisability of requiring submission of statutory and/or constitutional challenges to a private insurance company as a condition precedent to further administrative as well as judicial review of the Secretary's regulations. However, "[a] panel of this Court cannot overrule the decision of another panel. The prior decision remains controlling authority unless an inconsistent decision of the United States Supreme Court requires modification of the decision or this Court sitting *en banc* overrules the prior decision." *Salmi v. Secretary of Health*

[3] (h) Finality of Secretary's decision

The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h).

and Human Services, 774 F.2d 685, 689 (6th Cir. 1985) (citation omitted). Since we do not find the Supreme Court's holding in *Michigan Academy* to require modification of *Baptist Hospital*, we are constrained to follow that decision.

Therefore, the decision of the district court is AFFIRMED with respect to its grant of judgment in favor of the twenty-seven named hospitals in the amount of $2,965,767.00 plus statutory interest. The court's decision with respect to Bethesda and Deaconess Hospitals is REVERSED and REMANDED for dismissal in accordance with this opinion.

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 86-3090

BETHESDA HOSPITAL, ET AL.,
Plaintiffs-Appellees,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,
Defendant-Appellant.

Filed FEB 25, 1987

ORDER

Before: KEITH and GUY, Circuit Judges; and EDGAR, District Judge.*

The Secretary has filed a motion to correct judgment. The panel agrees and grants the Secretary's motion. The final paragraph of the opinion filed on February 2, 1987, is hereby amended to read as follows:

> Therefore, the decision of the district court is AFFIRMED with respect to its grant of judgment in favor of the twenty-seven named hospitals in the amount calculated by the Secretary pursuant to the distrcit court's amended order of February 20, 1986. The court's decision with respect to Bethesda and Deaconess Hospitals is REVERSED and REMANDED for dismissal in accordance with this opinion.

IT IS SO ORDERED.

Entered by Order of the Court

/s/ JOHN P. HEHMAN, CLERK
John P. Hehman
Clerk

*Honorable R. Allan Edgar, United States District Court, for the Eastern District of Tennessee, sitting by designation.

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 85-5473

BAPTIST HOSPITAL EAST, ET AL.,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES

October 6, 1986

Before: ENGEL and MILBURN, Circuit Judges, and CONTIE,* Senior Circuit Judge.

ENGEL, Circuit Judge. Appellants, five non-profit hospitals, are all providers of health care services under the Medicare program who, during the relevant period, provided some free health care to non-Medicare patients. These services were accounted for by the hospitals as either bad debts, charity or courtesy allowances.[1] The

* Judge Leroy J. Contie took senior status on July 1, 1986.

[1] The Secretary has defined bad debts, charity and courtesy allowances as follows:

(b) Definitions—(1) Bad debts. Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.

(a) Charity allowances. Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.

(3) Courtesy allowances. Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of

hosptials now seek reimbursement from the Medicare program for a portion of these services. They appeal a decision of the United States District Court for the Western District of Kentucky upholding 42 C.F.R. § 405.420 under which the Secretary of Health and Human Services denied their claims for reimbursement. We agree with Chief Judge Charles M. Allen that a provider's self-disallowance is not a matter covered by its cost report and does not preserve the jurisdiction of the Provider Reimbursement Review Board with respect to the self-disallowance, that Reg. Sec. 405.420 does not conflict with the reasonable cost provisions of the Medicare Act, 42 U.S.C. § 1395x(v)(1)(A), and that Reg. Sec. 405.420 does not violate the due process clause of the Fifth Amendment.

I.

To recover costs incurred in providing health care services to Medicare recipients, a provider must file a cost report with the Department of Health and Human Services, usually through a private insurance company acting as an agent for the Secretary and denominated a "fiscal intermediary." The appellants, in filing their cost reports with their fiscal intermediary, claimed compensation from the Medicare program for a portion of their bad debts, charity and courtesy allowances, while one appellant, William Booth Memorial Hospital, self-disallowed reimbursement for its free services on its cost report for fiscal 1981.[2] The fiscal intermediary rejected the claims for

the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances. 42 C.F.R. § 405.420(b).

[2] To self-disallow a cost, the provider lists that cost on Worksheet A-8 (adjustments to expenses) of its cost report, "but does not request reimbursement for that item because it believes that reimbursement is barred by the Medicare regulations." *Athens Community Hosp., Inc. v. Schweiker,* 743 F. 2d 1, 5 (D.C. Cir. 1984).

reimbursement for bad debts, charity and courtesy allowances in accordance with 42 C.F.R. § 405.420(b). The providers appealed as part of a group appeal from these denials to the Provider Reimbursement Review Board pursuant to 42 U.S.C. § 1395*oo*, challenging 42 C.F.R. § 405.420 and seeking expedited judicial review. Booth Memorial, along with other providers who had not claimed recovery for bad debts, charity and courtesy allowances sought to join the appeal to the Board.

The Board dismissed the appeals of several hospitals on the ground that it lacked jurisdiction to hear a claim not initially raised with the fiscal intermediary. It granted the remaining hospitals' request for expedited judicial review under 42 U.S.C. § 1395*oo*(f)(1) since only a controlling question of law, which the Board was not empowered to decide, remained at issue. The provider then filed suit in the district court.

The district court granted summary judgment against those hospitals, including Booth, which did not expressly claim reimbursement for their free services but made self-disallowing adjustments. It held that those hospitals had failed to satisfy the jurisdictional prerequisites for appeal to the Board.

> [A] mere self-disallowance, which is no more than setting out a figure on a cost report without claiming it, is insufficient to preserve the jurisdiction of the Board to consider that item for reimbursement purposes. . . . A provider simply cannot request reimbursement from the Board for an item which it did not even claim from its fiscal intermediary before receiving its NPR.

The court further upheld the challenged regulations as "entirely consistent" with the Medicare Act and as not in violation of the Fifth Amendment due process clause.

On appeal, the hospitals argue that bad debts and charity allowances are necessary costs of hospital operation, a portion of which are indirectly attributable to the Medicare program and are accordingly recoverable as reasonable costs under 42 U.S.C. § 1395x(v)(1)(A).[3] They contend that 42 C.F.R. § 405.420, which precludes recovery for general bad debts and charity allowances, is inconsistent with the reasonable cost provisions of the Act. They further contend that 42 C.F.R. § 405.420, to the extent it does not compensate the hospitals for costs of operation attributable to the Medicare program, effects a taking without compensation in violation of the due process clause of the Fifth Amendment. William Booth Memorial Hospital also contends that its self-disallowance of reimbursement for free services provided sufficient notice to preserve its right to appeal to the Board under section 1395*oo*.

II.

The review process for the claims of Medicare providers is established through 42 U.S.C. § 1395*oo*, in which Congress created the Provider Reimbursement Review Board.[4]

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[3] At oral argument, appellants relinquished their claim for recovery on courtesy allowances.

[4] Section 1395*oo* states:

> (a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider –
>
> (A)(1) is dissatisfied with a final determination of the organization serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report . . .
>
> (d) . . . The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with

Booth contends that the Board has jurisdiction under Sec. 1395*oo* to review the cost items that Booth self-disallowed since under that section the Board make "may any other revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making such final determination." Booth argues that the items it self-disallowed may be reviewed by the Board as items covered in the cost report and not considered by the intermediary.

There is a division of authority on this issue both within the circuits and within the district courts of this circuit. This circuit has held, though, that Sec. 1395*oo* "requires that a provider include disputed issues within the initial cost report and preserves the right of review if the intermediary ignores the claim, or instructs the provider to delete the claim. . . . The provider is not entitled to compel the Board to review *new* claims." *Saline Community Hosp. Ass'n v. Secretary of H. H. S.*, 744 F.2d 517, 519 (6th Cir. 1984) (per curiam) (original emphasis). By self-disallowing its bad debts, charity and courtesy allowances Booth did not claim them; on the contrary, through self-disallowance without an accompanying challenge, Booth expressly disclaimed entitlement to reimbursement. We do not believe that a mere self-disallowance even when made solely to conform to regulations with which a provider disagrees raises a claim within the meaning of *Saline* sufficient to preserve the issue for review by the Provider Reimbursement Review Board.

In *Athens Community Hosp., Inc. v. Schwicker*, 743 F.2d 1 (D.C. Cir. 1984) (*Athens II*), the D.C. Circuit held that "the PRRB has jurisdiction over costs that are specifically claimed—meaning that the provider requested

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respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination. 42 U.S.C. § 1395*oo*(a)(1)(A)(1) and (d).

reimbursement in a timely manner—as well as those cost issues raised by a provider prior to the intermediary's issuance of the NPR." Id. at 5-6. The court rejected the interpretation of section 1395*oo* stated by the Seventh Circuit in *St. Mary of Nazareth Hosp. Center v. Department of H.H.S.*, 698 F.2d 1337 (7th Cir.), *cert. denied*, 464 U.S. 830 (1983), which granted jurisdiction to the Board over all matters whether or not disclosed in the cost report.[5] It held that the interpretation would render meaningless the statute's provision for revision by the Board of "matters covered by [a] cost report." *Athens II*, 743 F.2d at 6. The court further held that section 1395*oo* does not grant jurisdiction to the Board over items self-disallowed on the cost report. It concluded that any other interpretation would put "an irrational gloss on the statute." Id.

> It simply is not plausible to contend that Congress has created a scheme where the provider can claim dissatisfaction and have recourse to an appeal procedure because the intermediary failed to read the provider's mind and anticipate all those things the provider would like to be reimbursed for, even though it did not request them. Id.

Moreover, it concluded that such an interpretation would place an overwhelming burden of identifying reimbursable costs on the intermediary.

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[5] The Seventh Circuit in *St. Mary* stated that "the statute allows the Board to consider matters outside of the cost reports. . . ." 698 F.2d at 1346. This statement, as the D.C. Circuit noted, ignores the second part of the jurisdictional grant in section 1395*oo*. The holding of *St. Mary*, however, is not necessarily so broad. See *St. Luke's Hosp. v. Secretary of H. H. S.*, 632 F. Supp. 1387 (D. Mass. 1986). In *St. Mary*, the provider had self-disallowed the costs for which it was seeking Board review. Accordingly, *St. Mary* could be limited to the proposition that section 1395*oo* extends Board jurisdiction to costs which were self-disallowed as "matters covered by [the] cost report. . . ." As noted below, we agree with the D. C. Circuit that even this interpretation of section 1395*oo* is unwarranted.

> Thus a provider could list every conceivable cost on its cost report, without claiming reimbursement, and hope that the intermediary will reimburse it for the reported but unclaimed costs, secure that it nevertheless will have until 180 days following the NPR to concoct some reasons to urge upon the PRRB for reimbursement of the unclaimed costs. Id.

It noted that permitting de novo claims at the Board level would generate baseless appeals and that such an interpretation runs counter to the process of progressive narrowing of issues reflected in the procedures for reopening a cost report.

We note that in the instant case Booth self-disallowed its bad debts and charity allowances simply because it was compelled to do so under the regulations. We further recognize that the intermediary has no authority to alter the Secretary's regulations governing reimbursement but must faithfully apply them as they stand. This is not a case, then, where extending jurisdiction over costs not claimed in the report would saddle the intermediary with an additional obligation. If the Board's jurisdiction were extended to this type of case, the Board would not have to search out unclaimed costs that were disallowed under close regulatory directives since, even if it had considered these costs, it could not have awarded reimbursement for them. Moreover, we recognize that in this situation, requiring a provider to claim reimbursement does not serve the purpose generally served by exhaustion requirements. Since the intermediary cannot review the Secretary's regulations, it cannot offer the assistance of its analysis. See *Bethesda Hosp. v. Heckler,* 609 F. Supp. 1360, 1368 (S.D. Ohio 1985). Booth's interpretation of Sec. 1395*oo* does not in these circumstances "deprive [the PRRB] of the intermediary's analysis and conclusions and make the PRRB the tribunal of original jurisdiction, eliminating a tier of review, and possibly substantially slowing the

reimbursement process for other providers." *Athens Community Hosp. Inc. v. Schweiker,* 686 F.2d 989, 997 (D.C. Cir. 1982) (*Athens I*), *modified,* 743 F.2d 1 (1984).

Nonetheless, even if we see little reason for requiring a provider to raise a claim before a body that cannot address it, we are not free to design an agency process for review of intermediary decisions on cost reports, but are bound to apply Congress' intent where it can be determined and to defer to the Secretary's interpretation where it is reasonable. We agree with the D.C. Circuit that the interpretation stated by the Seventh Circuit renders the second part of the jurisdictional grant meaningless. Moreover, we agree that the interpretation which grants jurisdiction over costs for which the provider did not seek reimbursement places an irrational gloss on the statute. The interpretation adopted in *Athens II* and applied by the Board in this and other cases, in contrast, does no damage to the language of the statute and serves a beneficial procedural purpose. Under *Athens II* and the Board's interpretation, a provider is required to present a coherent claim for reimbursement at the time it files its cost report. It may not present claims to it intermediary, await the intermediary's decision, and then decide based upon its success before the intermediary whether to raise additional claims before the Board. "This procedure would . . . render virtually meaningless the time limits for the filing of cost reports established by Medicare regulations." *Athens II,* 743 F.2d at 7.[6] Finally, we note

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[6] In *Bethesda,* Judge Spiegel expressed concern that the interpretation of section 1395*oo* adopted in *Athens II* would preclude review by the Board and the courts of errors made by an intermediary in favor of a provider. We do not fear such a result. Section 1395*oo*, permits the Board to make "revisions adverse to the provider of services." This provision clearly allows the Board to reach issues not raised by the provider in its appeal. It is not inconsistent with the requirement that a provider claim a cost with its intermediary before seeking reimbursement for that cost at the Board. It simply allows the Board to make any revisions to the NPR mandated by its decision on the issue

that the interpretation adopted here does not place the provider at any disadvantage for exercising its right to challenge in good faith regulations which it believes are in conflict with their statutory underpinnings.[7] The *Provider Reimbursement Manual* states that there will be no referral to the U.S. Attorney for criminal and/or civil prosecution of a provider where the provider has claimed reimbursement for disallowed costs so long as "[t]he provider clearly indicates this item(s) is being included in the cost report only to establish the basis for an appeal and each disputed item and amount is specifically identified." *P. R. Manual* § 2425.1. [now *Manual* Sec. 2905.2, ¶ 7665] Moreover, under the reasoning of *Athens II*, a provider is able to appeal to the Board when it has self-disallowed a cost but also timely indicated its disagreement with and challenge to the regulations or rulings compelling the self-disallowance.

In the present case, Booth did not claim reimbursement for its bad debts and charity or courtesy allowances in its initial cost report but instead self-disallowed reimbursement for those matters and did not challenge the regulations under which it self-disallowed. Accordingly, Booth's bad debts and charity and courtesy allowances are not claims and the Board lacked jurisdiction to consider them.

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appealed, regardless of whether that revision was raised as an issue by the provider. Thus, if the provider appeals the denial of one claim and the Board's reversal of the intermediary's denial would necessitate a revision of other claims, the Board is empowered to make those revisions.

[7] Several courts have expressed concern that requiring a provider to claim a cost as a prerequisite to Board and judicial review places the provider in an untenable position when the cost has previously been denied by its intermediary or the Secretary. See *St. Luke's Hosp. v. Secretary of H. H. S.*, 632 F. Supp. 1387 (D. Mass. 1986); *Community Hosp. of Roanoke Valley v. Heckler*, 588 F. Supp. 674, 678 (D. Va. 1984), *aff'd in part and rev'd in part*, 770 F. 2d 1257 (4th Cir. 1985); *Adams House Health Care v. Heckler*, 604 F. Supp. 110, 115 (N. D. Cal. 1984); *Our Lady of Lourdes Memorial Hosp. v. Schweiker*, No. 80-CV-226 slip op. (N. D. N. Y. July 26, 1982).

III.

Those hospitals that did claim reimbursement on their cost reports for their charity allowances and bad debts contend that 42 C.F.R. § 405.420 is inconsistent with the reasonable cost provisions of the Medicare Act.

The Medicare Act allows for the payment of, at most, the "reasonable cost" of health care services to providers who charge the public more than a nominal sum for such services. 42 U.S.C. § 1395f(b).[8] Congress defined "reasonable cost" as the amount actually incurred and necessary to the efficient delivery of needed health services. 42 U.S.C. § 1395x(v)(1)(A).[9] Congress left the imple-

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[8] At the time the hospitals filed their cost reports, sec. 1395f(b) provided:

> The amount paid to any provider of services (other than a hospice program providing hospice care) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1395e and 1395ww of this title, be—
>
> (1) except as provided in paragraph (3), the lesser of (A) the reasonable cost of such services, as determined under section 1395x(v) of this title and as further limited by section 1395rr(b)(2)(B) of this title, or (B) the customary charges with respect to such services. . . .

[9] 42 U.S.C. § 1395x(v)(1)(A) provides:

> (1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services . . . Such regulations [establishing the method to determine costs] shall (i) take into account both direct and indirect costs of providers of services . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

mentation of this definition to the Secretary, but required that any regulations account for indirect as well as direct costs and further provided:

> [T]he necessary costs of efficiently delivering covered services to individuals covered by the insurance programs . . . will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs. . . 42 U.S.C. § 1395x(v)(1)(A)(i).[10]

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[10] Pursuant to this authority, the Secretary promulgated the following regulations:

> (a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program. . . .
>
> (d) *Requirements for title XVIII.* Under Title XVIII of the Act, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the health insurance program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the health insurance program. Uncollected revenue related to services rendered to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts can result in the related costs of covered services being borne by other than beneficiaries of title XVIII. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts which remain unpaid are added to the title XVIII share of allowable costs. Bad debts arising from other sources are not allowable costs.
>
> (e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:
>
> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
>
> (2) The provider must be able to establish that reasonable collection efforts were made.
>
> (3) The debt was actually uncollectable when claimed as worthless.

The hospitals argue that "the legislative history is clear" that through the Medicare Act Congress "intended to pay actual costs to meet the financial requirements of efficiently operating and maintaining a hospital." They maintain that their bad debts and charity allowances are actual indirect costs which must be recovered to operate a hospital efficiently and therefore are necessary to effectively deliver needed health care services to individuals covered by the Medicare program. Consequently, they contend that bad debts and charity allowances fall within the definition of reasonable costs and that the regulations disallowing partial reimbursement for bad debts and charity are inconsistent with the Act. The Secretary, though, contends that these are not actual costs attributable to health care services provided to recipients of Medicare assistance and that the system of allocating costs under the existing regulations is not inconsistent with the Act.

When construing the Medicare Act, we must defer to the interpretation made by the Department of Health and Human Services as the agency charged with administration of the statute. See *Schweiker v. Hogan,* 457 U.S. 569, 588 (1982). The Secretary's interpretation must be analyzed in light of the statute's language, purpose and history, and should be upheld if it is reasonable, consistent with the statutory mandate and does not frustrate the policy that Congress sought to implement. *Southeastern Community College v. Davis,* 442 U.S. 397 (1979); *Connecticut Dept. of Income Maintenance v. Heckler,* 105 S. Ct. 2210, 2215 n. 21 (1985); *State of Ohio v. United States Dept of Health & Human Serv.,* 761 F.2d 1187, 1193 (6th Cir. 1985).

> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future. . . .
>
> (g) *Charity allowances.* Charity allowances have no relationship to beneficiaries of the health insurance program and are not allowable costs. . . . 42 C.F.R. § 405.420.

The Seventh Circuit has held that the regulations challenged here are "in complete harmony with both the letter and the spirit of the statue. . . ." *St. Francis Hosp. Center v. Heckler,* 714 F.2d 872, 887 (7th Cir. 1983), *cert. denied,* 465 U.S. 1022 (1984). We agree. The Secretary's regulations permit hospitals to recover from the Medicare program the uncollectible receipts, whether accounted for as bad debts or charity allowances, that are due from Medicare patients themselves. The Secretary has thus ensured the health care providers will not operate at a loss on the services provided to Medicare insureds. Congress did not require the Medicare program to reimburse health care providers for the proportion of their bad debts and charity allowances equal to the proportion of their patients who are Medicare insureds. That this might also be a reasonable scheme under the Act is not relevant. We need only consider whether the Secretary's regulations are reasonable in light of the Act; they need not be the only reasonable application of the Act. *Connecticut Dept. of Income Maintenance,* 105 S.Ct. at 2215. The characterization of bad debts and charity allowances as reductions in revenue rather than operating costs, and the Secretary's decision to pay the bad debts and free care costs of Medicare patients and to deny reimbursement for bad debts and free care of non-Medicare patients, is not an unreasonable scheme for allocating health care costs and does not conflict with the meaning of Sec. 1395x(v)(1)(A) as revealed by its language, purpose and history.

The Senate report provides an example of what Congress contemplated would be a reimbursable cost as well as what would not be reimbursable under the Medicare Act. It states that costs incurred by a health care provider pursuant to educational activities would be recoverable under the Medicare program because, "they enhance the quality of care in an institution," and are not borne by the community in any other way. S. Rep. No. 404, 89th Cong., 1st

Sess., *reprinted in* 1965 U.S. Code Cong., & Ad. News 1943, 1977. However, the report states that recovery would be denied for identifiable expenses for medical research:

> Identifiable expenses for medical research, on the other hand, over and above the costs closely related to normal patient care, would not be met from the trust fund. Available research funds are generally ample to support important basic medical research. Id.

Unquestionably, charity allowances and lost revenues attributable to bad debts reduce a hospital's gross receipts.[11] This will be true whether the particular loss was occasioned by motives of charity, by poor fiscal management, or simply by normal risk-taking inherent in every undertaking. It is also true that uncollected accounts receivable, like increased expenses incurred in providing patient care, can be made up by raising charges for normal patient care. In our judgment these factors do not, however, entitle them to be treated as costs "closely related to normal patient care" as Congress meant that term to be understood in the Medicare Act.

The hosptials, in essence, do not complain that the Secretary has refused reimbursement for a portion of the costs that a hospital must incur to properly service all its patients. Rather, they contend that they are not receiving from charges to patients a return sufficient to continue

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[11] The Secretary's regulations do not ignore the need of proprietary hospitals to recover economic costs through a sufficient return on equity. They provide for the payment of a reasonable return on equity either as part of or in addition to reimbursement of reasonable costs. See 42 U.S.C. § 1395x(v)(1)(B), 42 C.F.R. § 405.429. Congress, however, did not intend nonproprietary facilities, such as appellants, to collect a return on equity capital as part of the "reasonable costs" of providing services. *St. Francis,* 714 F. 2d at 875.

operation of the hospital or engage in improvements. While Congress intended to provide for reimbursement of normal patient care costs, contrary to the hospital's contention, neither the legislative history nor subsequent cases reveals a Congressional intent to guarantee a return from overall hospital functions adequate to ensure sustained hospital operation. In enacting the Medicare program, Congress did not primarily seek to ensure the financial viability of individual health care institutions, but sought to ensure adequate health care for a specific group of people.

> We do not find in the statute authorizing Medicare and Medicaid any legislative intention to provide financial assistance to providers of care for their own benefit. Rather, the statute is designed to aid the patients and clients of such facilities. *Green v. Cashman*, 605 F.2d 945, 946 (6th Cir. 1979).

It is evident that when Congress enacted the Medicare program it considered the problems that bad debts and free care pose for health care institutions. It recognized that the program would in reality provide a major source of relief from the risk of economic loss through payments on behalf of the elderly; just as plainly it did not intend to assume the risk incurred in serving those not covered by the program.

> In some cases, the charges hospital patients pay include a share of the cost of rendering services to free and part-pay patients as well as a share of uncollectible bills. The committee has given careful consideration to the question of the effect that the proposed program would have on charges to other paying patients. The insurance system will reduce the losses of hospital income from bad debts or for care of free or part-pay aged patients which might otherwise be included in charges to other paying patients by paying the full cost, execpt for the deductible and coinsurance, for substantially all patients over 65. Under the public assistance programs now existing and even more as they would exist under the provisions of this bill, the Federal Government will make a very substantial contribution toward the medical care of the needy of all ages. Under the bill more of the needy could be aided under the Federal-State assistance programs. Further, the proposed amendments would require under the medical assistance and maternal and child health and crippled children programs of the Social Security Act, the payment of the reasonable costs of covered hospital services. This will assist hospitals in reducing income deficits arising out of providing hospital care to persons unable to pay for care. These provisions, taken in combination with the hospital insurance system under part A of title XVIII, will appreciably reduce the need of hospitals to charge their paying and prepaying patients more than the cost of their services in order to compensate for care rendered to other patients without charge or at less than cost. The bill will thus make a contribution toward rationalizing the distribution of hospital costs and relieving voluntary insurance and prepayment systems, as well as those patients who pay for services at the time when they are rendered, of some part of the burden they now bear for indigent and charity patients. S. Rep. No. 404, 1965 U.S. Code Cong. & Ad. News at 1977-78.

Congress has enacted other programs to help ensure an ample number of health care institutions, see, e.g., 42 U.S.C. § 261a; *Newsom v. Vanderbilt University*, 653 F.2d 1100, 1104-05 (6th Cir. 1981), and we have held that the Medicare Act does not also serve that purpose. In the face of arguments similar to those raised here, courts have repeatedly held that free care costs incurred by the health care providers in satisfaction of obligations they assumed

in order to receive federal funding under the Hill-Burton Act are not recoverable as reasonable costs under the Medicare program because the Medicare Act was not designed to finance improvements in health care facilities.

> [T]hese two Acts as established are two separate and distinct federal programs, each designed to accomplish a distinctly different purpose. The Hill-Burton Act was designed to promote the construction and modernization of hospitals. . . . The Medicare Act, on the other hand, was adopted only to provide medical care for the disabled and the aged who qualify as Medicare beneficiaries. *St. Mary,* 698 F.2d at 1343. See also *Harper-Grace Hosps. v. Schweiker,* 691 F.2d 808 (6th Cir. 1982), *reh'g denied,* 708 F.2d 199 (6th Cir. 1983).

The regulations restricting reimbursement of bad debts and charity allowances to those bad debts and charity allowances arising from a Medicare recipient's failure to pay outstanding medical care costs and characterizing bad debts and charity allowances as reductions in revenue rather than operating costs are not unreasonable. They neither conflict with nor frustrate the Congressional policies underlying section 1395x(v)(1)(A).

IV.

In the hospitals' final challenge to 42 C.F.R. § 405.420, they contend that Reg. Sec. 405.420 violates the Fifth Amendment due process clause. They contend that the Secretary has denied them just compensation and argue that even public service corporations may not be compelled to operate at a loss.

The just compensation to which the hospitals are entitled is just compensation for providing health care services for Medicare recipients, not just compensation for operating a health care facility. As noted above, Reg. Sec. 405.420 adequately compensates for services to Medicare

patients, and the Act neither requires nor permits more. Moreover, Reg. Sec. 405.420 does not compel any hospital to operate at a loss. The Medicare Act does not require any provider to render free services, nor does it restrain any provider from instituting measures to reduce its volume of bad debts.

Finally, participation in the Medicare program is wholly voluntary. If any provider fears that its participation will drive it to insolvency, it may withdraw from participation.

> The hospital's argument might well prove persuasive if participation in the Medicare program were mandatory. However, Medicare is a federally sponsored insurance program for the aged and disabled, 42 U.S.C. § 1395c, and provider participation is voluntary, 42 U.S.C. § 1395cc. Providers who opt not to participate are free to serve persons not covered by Medicare and those potential Medicare recipients who are willing to forego Medicare benefits for the services provided. As a practical matter, perhaps a few of those persons eligible for Medicare would choose a non-participating hospital, but the fact that practicalities may in some cases dictate participation does not make participation involuntary. Even those hospitals that have an obligation to participate in the Medicare program because of their receipt of funds under the Hill-Burton Act, 42 U.S.C. § 291; 42 C.F.R. § 124, made a voluntary choice to accept both the obligations and the benefits of Hill-Burton funding. *St. Francis Hosp. Center v. Heckler,* 714 F.2d 872, 875 (7th Cir. 1983), *cert. denied,* 465 U.S. 1022 (1984).

The hospitals finally appear to contend, however, that participation in the Medicare program is not truly voluntary because, they argue, they must participate in order to maintain their tax-exempt status. Even if the hospitals have correctly characterized the requirements for tax-

exempt status, we do not think that requirement affects either the voluntariness of their participation or the absence of any obligation by the federal government to allay a part of their financial burden resulting from bad debts and acts of charity. The decision to seek tax-exempt status, like the decision to accept Hill-Burton funds, is purely voluntary and any obligations are as freely accepted as the benefits.

AFFIRMED.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

No. C-1-83-622

BETHESDA HOSPITAL, ET AL.,

Plaintiffs,

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendant.

MEMORANDUM OPINION

Filed April 30, 1985

SPEIGEL, J.:

INTRODUCTION

In this action, plaintiffs challenge the validity of an administrative regulation governing reimbursement of malpractice insurance costs associated with the care of Medicare patients. The following issues are raised: 1) Whether the Provider Reimbursement Review Board (PRRB) erred in concluding that it lacked jurisdiction over the claims of plaintiffs who self-disallowed malpractice insurance costs? 2) Is the challenged regulation invalid under the Administrative Procedure Act (APA) because of deficiencies in either the Notice of Proposed Rule Making or the Basis and Purpose statement accompanying the regulation in final form? 3) Is the challenged regulation violative of the APA as arbitrary and capricious, an abuse of

discretion or otherwise not in accordance with law? 4) Is the challenged regulation invalid because it is inconsistent with the Medicare Act?

Having reviewed the administrative record and the filings by counsel, and having heard the able arguments of counsel, we reach the following conclusions: 1) The PRRB erred in concluding that it lacked jurisdiction over the claims of the health care providers who "self-disallowed" the malpractice insurance costs; 2) the challenged regulation is violative of the APA in two respects: a) the regulation in final form was not accompanied by an adequate statement of basis and purpose; and b) the issuance of the regulation, based upon the data on which the Secretary relied, was arbitrary and capricious. We do not rule on the issue of whether the challenged regulation is invalid because of alleged inconsistency with the Medicare Act.

I. Factual Background

This case involves a challenge to the new method for reimbursement to health-care providers of malpractice insurance costs associated with the treatment of Medicare patients. The new Malpractice Rule was promulgated by the Department of Health and Human Services in 1979, and is codified at 42 C.F.R. § 405.452(b)(1)(ii) (1984).

The new Malpractice Rule is a marked departure from the previous method of calculating malpractice insurance costs associated with care of Medicare patients. The old approach lumped malpractice insurance costs into the category of General and Administrative costs (G&A costs). G&A costs include a variety of indirect costs associated with patient care. The old regulations provided for application of the provider's overall Medicare utilization ratio to allocate the G&A costs between Medicare and non-Medicare patients. The utilization ratio is the ratio of Medicare patients to the total patient population of the provider hospital.

The challenged regulation, specifically excepts malpractice insurance costs from the category of G&A costs, and thus, abandons the previous approach entirely. Malpractice insurance costs now constitute a separate category of health care costs. The extent to which Health and Human Services will reimburse the provider for malpractice insurance costs is "based on the dollar ratio of the provider's Medicare paid malpractice losses to its total paid malpractice losses for the current costs reporting period and the preceding 4-year period." 42 C.F.R. § 405.452(b)(1)(ii). If a provider has paid no malpractice claims within the applicable five-year period, it is reimbursed at the "national average" ratio of 5.1 per cent. This formula does not consider the Medicare utilization ratio of the provider.

Plaintiffs are providers of hospital services in the State of Ohio who mount this group challenge to the new Malpractice Rule. Of this group, all but two providers have undisputedly perfected their claim to judicial review in this Court. However, the Secretary seeks dismissal of the claims of Bethesda and Deaconess Hospitals, alleging, that this Court lacks jurisdiction over their claims (*see* docs. 37, 43). This jurisdictional issue is best addressed at the outset.

Plaintiffs Bethesda and Deaconess differ from other plaintiffs in that they did not file a claim with the fiscal intermediary[1] for reimbursement of malpractice insurance costs allowable under the old rule but now excludable under the new rule. Instead, Bethesda and Deaconess filed their cost reports with the fiscal intermediary in compliance with the new Malpractice Rule, and hence "self-disallowed" reimbursement for the additional portion of malpractice insurance costs allowable under the old rule.

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[1] The fiscal intermediary is a private entity which, under contract with the Department of Health and Human Services, performs a major administrative role in the operation of the Medicare program. See discussion pp. 11-13 *infra*.

Consequently, the PRRB concluded that, under the statutory administrative review scheme, 42 U.S.C. § 1395oo(a)-(f), it lacked jurisdiction over their appeal from the final determination of the fiscal intermediary because Bethesda and Deaconess made no claim for reimbursement to the intermediary (doc. 43, attachment A).

II. Jurisdictional Issues – "Self-disallowed Costs"

The relevant portions of the administrative review scheme are as follows:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if –
>
> (1) such provider –
>
> > (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payments may be made under this subchapter for the period covered by such report,
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> • • • •

> > (2) the amount in controversy is $10,000 or more, and
> >
> > (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

42 U.S.C. § 1395oo(a)(1)-(3).

> A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

42 U.S.C. § 1395oo(d).

The precise issue before us is whether the malpractice insurance costs disclosed on the cost reports by Bethesda and Deaconess but not claimed by those providers as reimbursable costs are "matters covered by such cost reports" over which the PRRB has jurisdiction to review within the meaning of § 1395oo(d).

As evident from the quoted provisions of the statute, section 1395oo contemplates that the PRRB may conduct an adminstrative review of the intermediary's final decision. Perhaps less obvious but nevertheless evident is the legislative intent that the PRRB review need not be limited to costs claimed by the provider to the intermediary in the cost report. Consequently, we conclude that the PRRB erred in concluding that it lacked jurisdiction over the claims of Bethesda and Deaconess Hospitals.

The administrative review scheme contemplated by the statute is as follows: A cost report is submitted first to the fiscal intermediary. The fiscal intermediary determines reimbursement based upon the cost report. If the provider is dissatisfied with the final determination of the fiscal intermediary, and the amount in controversy is greater than or equal to $10,000.00, and the provider files a request for a hearing within 180 days, then the matter is properly subject to PRRB review. PRRB may then pass upon the final determination of the fiscal intermediary with respect to the cost report and make revisions on matters covered by the cost report.

A long established rule of statutory construction is that the words in the statute are to be given their ordinary and intended meaning. *See, e.g., Old Colony Ry. Co. v. Comm. of Internal Revenue*, 284 U.S. 552, 560 (1932) and cases cited therein. Applying this principle to section 1395oo(d), a requirement of an overt claim for reimbursement to the fiscal intermediary as a condition precedent to PRRB review is implicit at best, and in apparent contradiction to the broad grant of authority to the PRRB to revise "matters covered by [the] cost report even though such matters were not considered by the intermediary in making such final determination." 42 U.S.C. § 1395oo(d). However, where case authority exists, we hesitate to base our decision exclusively upon the language of the statute.

Section 1395oo has engendered considerable litigation; however, in the interests of brevity and clarity of thought, we limit our discussion of the statute to the decisions of the Sixth, Seventh, and D.C. Circuit Courts of Appeal.

At issue in *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337 (7th Cir. 1983), *cert. denied*, 104 S. Ct. 107 (1983) (hereinafter *St. Mary*) was whether personal telephones were "personal comfort items," and hence, whether costs associated with such phones were therefore not subject to reimbursement. *St. Mary* included the incidental issue of the PRRB's jurisdiction over claims of one provider who had "self-disallowed" the telephone costs. In a decision based largely upon the language of the statute the Seventh Circuit interpreted section 1395oo(d) as a broad grant of jurisdiction to the PRRB to "consider matters outside cost reports." 698 F.2d at 1337. Thus the Seventh Circuit concluded that the PRRB had jurisdiction over the self-disallowed costs and proceeded to the merits of the claim.

The Sixth Circuit has arguably taken a more restrictive view of the jurisdictional grant of authority to the PRRB contained in section 1395oo, at least where the costs claimed in the PRRB appeal were not included in the cost report in any fashion. In *Saline Community Hospital Association v. Secretary of Health and Human Services*, 744 F.2d 517 (6th Cir. 1984), health care providers sought to amend their 1979 cost reports to add claims for return on net-invested-equity capital—costs which had never been included on the 1979 cost reports in any fashion. The PRRB denied jurisdiction. Judicial review at the district court level proceeded over two motions to dismiss, and the Secretary ultimately prevailed on the merits. On appeal, the Sixth Circuit held that the costs in issue were improperly tendered as amendments since the providers had never included them in the cost reports, and therefore, the PRRB was correct in denying jurisdiction. *Id.* at 520. The

Court also held that the only issue properly before the district court was whether the PRRB erred in concluding that it lacked jurisdiction, and that the trial court should not have reached the merits of the providers' claims. *Id.* at 521.

While instructive, *Saline* is not entirely on point. It is not a self-disallowance case. Therefore, it does not address the issue of the PRRB's jurisdiction over costs disclosed on the cost report but not actually claimed before the fiscal intermediary as reimbursable costs.

We also have the benefit of two D.C. Circuit Court of Appeals decisions. *Athens Community Hospital, Inc. v. Schweiker,* 743 F.2d 1 (D.C. Cir. 1984) (*Athens II*) *modifying Athens Community Hospital, Inc. v. Schweiker,* 686 F.2d 989 (D.C. Cir. 1983) (*Athens I*). At issue in *Athens I and II* were a provider's claims for income tax costs and stock option costs associated with providing health care. Interpreting the stock option costs as matters not covered by the cost reports, and the income tax expenses as self-disallowed costs at best, the Court concluded that the PRRB was correct in concluding it had no jurisdiction because the intermediary was never given the opportunity to rule on the costs in issue. *Id.* at 10. In so holding, the Court through Judge Bork developed a useful, analytical construct for determining the breadth of the jurisdictional grant contained in section 1395oo(d).

Judge Bork views section 1395oo as containing two separate jurisdictional grants to the PRRB. First, it gives the PRRB the "power to affirm, modify or reverse final determinations of the fiscal intermediary with respect to the cost report." 42 U.S.C. § 1395oo(d). Second, PRRB is given the power "to make other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination." *Id.* Satisfaction of either provision vests jurisdiction in the PRRB. 743 F.2d at 4.

The D.C. Circuit acknowledged the difficulty in reconciling these two jurisdictional grants and recognized that these grants permit of a variety of different readings. The Court thereafter suggested that these readings fall into three general categories. The first category contemplates that the PRRB has jurisdiction only over those costs specifically claimed for reimbursement in the cost report presented to the fiscal intermediary. The second category considers the PRRB's jurisdiction to extend to those items disclosed to the fiscal intermediary in or with the cost report. The third category views the PRRB's jurisdiction as covering matters not disclosed to the intermediary through the cost report, but asserted for the first time to the PRRB on appeal from the fiscal intermediary's final determination. *Id.* at 4-5.

It is readily apparent that the first and third categories do not admit to considerations of degree. The first category permits the PRRB to review only those items specifically claimed before the fiscal intermediary. The third category permits any costs to be claimed as reimbursable before the PRRB. One category is precisely limited, the other category is all inclusive. Neither requires further interpretation. In contrast, the middle category, focusing as it does on "disclosure," admits to a large degree of interpretation. Indeed, as the D.C. Circuit recognized, a disclosure rule might include a reasonableness standard which would include as adequately disclosed anything the fiscal intermediary reasonably should have known. 743 F.2d at 4-5.

Following this discussion, the D.C. Circuit suggested that

> "the only . . . way of reading the statute that does give effect to both clauses of section 1395oo(d) . . . is to interpret the statute as allowing the PRRB to revise the aspects of the reimbursement calculation not actually contested by the provider, and possibly not

> considered by the intermediary (because not claimed for reimbursement by the provider), when such revision is necessary to accommodate other PRRB revisions of matters that were claimed by the provider, decided adversely by the intermediary, and then contested by the provider to the PRRB. The provider, however, is allowed to appeal only such adverse decisions of the intermediary.

Id. at 9.

In effect, the D.C. Circuit has implemented a nexus requirement, limiting the PRRB's jurisdiction over those matters not specifically addressed by the fiscal intermediary to claims which are "necessary to accommodate" revisions of any claims specifically asserted before the fiscal intermediary. However, the D.C. Circuit did not endeavor to further define the nexus requirement.

We respectfully decline to adopt the D.C. Circuit's nexus test. There is no such nexus requirement in the language of the statute. Indeed, the parenthetical in the statute providing for "revisions adverse to the provider of the services" seems to be inconsistent with the nexus requirement. 42 U.S.C. § 1395oo(d). For if such a requirement existed, this parenthetical would necessarily be too broad. Under the nexus rule, the PRRB could make revisions adverse to the provider of the services only where such revisions were necessary to accommodate items specifically claimed before the fiscal intermediary. This reasoning is contrary to the language of the parenthetical, and could produce the anamolous result of the fiscal intermediary making an error in favor of the provider and an unrelated error in favor of the Secretary. On appeal of the adverse determination, the nexus rule would vest the PRRB with jurisdiction only over the error adverse to the provider, and the PRRB would have no power to correct the error made in favor of the provider, even though all facts and figures necessary to make such correction were

included on the original cost report. We do not think that this result nor the reasoning which leads to this result reflects the intention of Congress in enacting this administrative review scheme.

Our conclusion is based in part on H. Rep. No. 92-231, *reprinted in* 1972 U.S. Code Cong. & Admin. News. 92nd Cong., 2d Sess., 4989, 5094-5095. In this report, Congress envisioned the review process as follows:

> [A]ll decisions by the board [PRRB] would have to based upon the record made at such hearing [before the board], which may include any evidence submitted by the Department. Such evidence would include the evidence or record considered by the intermediary. Based upon examination of *all* the evidence, the Provider Reimbursement Review Board may find in whole or in part for the provider or the Government (*including a finding based upon the evidence before it that the provider owes sums in addition to the amount raised in the appeal*). (emphasis added)

It is clear from this parenthetical that Congress intended the PRRB to have the final say on reimbursable costs which were included in the evidence presented to the intermediary even if such costs were not specifically claimed as reimbursable and hence, not considered by the intermediary.

An examination of the role of the fiscal intermediary in the reimbursement process indicates that Congress naturally might have vested the PRRB with broad powers of review over intermediary determinations. Fiscal intermediaries were first designated in the Social Security Amendments of 1965, P.L. 89-97; 79 Stat. 286 *reprinted in* 1965 U.S. Code Cong. & Admin. News, 89th Cong. 1st Sess., 305. The legislative history of those amendments indicates that the fiscal intermediary was to perform a "major administative role," as a private entity under contract with the administrative agency, in the administration of

the Medicare program. The specific powers and responsibilities of the fiscal intermediary contemplated by Congress were to determine the amount of payments due providers upon presentation of the providers' claims and to make such payments; to serve as a conduit of information between the providers and the agency; and to provide consultative services; to assist providers to establish and maintain necessary records; and to assist providers in meeting the qualifications requirement for participation in the Medicare program. Intermediaries could also be employed to audit provider records and to perform related functions. S. Rep. 404 *reprinted in* [1965] U.S. Code Cong. & Admin. News, 89th Cong. 1st Sess. pp. 1943, 1949, 1992-95. Although the 1972 amendments set up the administrative review scheme now under consideration (*see* p. 11 *supra*), the 1972 amendments contained no indication of any major change in the function of fiscal intermediary. Thus the function of fiscal intermediary is and always has been that of an administrator, informational conduit, and auditor.

We acknowledge that some interpretation of agency regulations is implicit in the job of fiscal intermediary. But aside from such implicit interpretative power, the legislative history indicates no vesting of deliberative authority in the fiscal intermediary. Thus it is only natural that Congress would not envision the unchallenged determinations of the fiscal intermediary to be beyond review by the agency absent some connection with a challenged claim.

The absence of any large measure of deliberative authority in the fiscal intermediary's function undercuts the Secretary's argument in another respect. By arguing that the PRRB has no jurisdiction over claims which were not presented to the fiscal intermediary, the Secretary advances what is in essence an exhaustion of administrative remedies argument. On the facts of this case, requiring providers to submit the claims involved to the fiscal inter-

mediary is particularly inappropriate. First, the malpractice rule requires no interpretation. Both the old and new rules are mathematically precise and submit easily to mechanical application. Second, the fiscal intermediary is not authorized to grant the relief sought. Plaintiffs here are not challenging the application of rule to particular facts. Rather, they challenge validity of the rule itself because of alleged illegality in its inception and its asserted inconsistency with the Medicare Act. We think it is clearly beyond the role of the fiscal intermediary, as a prviate agency operating under contract with the Department of Health and Human Services, to review the legality of a regulation entrusted to it for application. Therefore, as "the exhaustion doctrine contemplates an efficacious remedy," *Humana of South Carolina, Inc. v. Califano,* 590 F.2d 1070, 1081 (D.C. Cir. 1981), (quoting *Wallace v. Lynn,* 507 F.2d 1186, 1190 (D.C. Cir. 1974)), and the fiscal intermediary can provide no meaningful remedy on these facts, we will not infer an exhaustion of remedies requirement where none is explicitly stated by the statute or indicated appropriate by the legislative history.

Based upon the foregoing analysis, we conclude that the grant of authority to the PRRB to review determinations made by the fiscal intermediary contained in section 1395oo(d) is more appropriately limited to those items disclosed in the cost report such that all figures necessary to any calculations are contained in the cost report. Therefore, we conclude that the PRRB erred in concluding that it had no jurisdiction to review Bethesda and Deaconess Hospitals' claims for reimbursement of self-disallowed costs. However, that is the extent of our review. We do not proceed to the merits of plaintiffs' claims as regard Bethesda and Deaconess because of the clear instruction of *Saline,* 744 F.2d 517 at 521.

III. THE VALIDITY OF MALPRACTICE INSURANCE RULE

(A) Additional Factual Background Necessary to a Decision on the Merits

The Notice of Proposed Rule Making (NPRM) was published on March 15, 1979, 44 Fed. Reg. 15,744. The NPRM indicated that a forty-five day period for public comment would be observed as a passage of the rule was being expedited for implementation in fiscal year 1979. *See* "Action Memorandum" Administrative Record Volume 1, Tab 28. This forty-five day comment period represented a departure from Executive Order 12044 which established a sixty day comment period for proposed regulations. 43 Fed. Reg. 12,661 (March 24, 1978).

The rule proposed in the NPRM was justified by an allusion to "a study conducted by an HEW consultant" which indicated that closed malpractice claims involving Medicare patients were generally lower than such claims involving non-Medicare patients. 44 Fed. Reg. 15,745. The NPRM contained no other justification for the agency's conclusion that Medicare was bearing a disproportionate share of malpractice insurance costs. The study mentioned was neither identified nor offered for public perusal. On May 1, 1979, the agency issued a notice reopening the comment period for an additional fifteen days, thereby bringing the notice in compliance with Executive Order 12044 *supra*. 44 Fed. Reg. 25,476.

On June 1, 1979, HEW published the final form of the regulation. 44 Fed. Reg. 31,641-42, codified at 42 C.F.R. § 405.452(b)(1)(ii). The preamble to the final rule acknowledged that "all comments received were against proposal and recommended that [HEW] withdraw it entirely." 44 Fed. Reg. 31,641. There were approximately six hundred comments from interested parties in opposition to the regulation. Administrative Record Vols. 5-8.

The final form of the malpractice rule was published against the recommendation of the Deputy General

Counsel for Regulation Review, Administrative Record Vol. 2, Tab 49, who noted that the preamble was inadequate and poorly written and cautioned that as all comments opposed the proposed regulation, there was a need for careful explanation of the rejection of such comments. *Id.* However, other than acknowledging that all comments received were against the proposed regulation, the agency did not address such comments in significant detail when promulgating the rule in final form. 44 Fed. Reg. 31,641-42.

The study alluded to in the NPRM was identified in the final rule as the Medical Malpractice Closed Claim Study, 1976 performed by Westat, Inc. (hereinafter Westat study). The Westat study consisted of an analysis of malpractice claims closed by nine companies during a four month period in 1976. Administrative Record Vol. 3 at 1-2, 1-3 & 2-1. The authors of the study noted that it was not the purpose of the study to make national yearly estimates. Administrative Record Vol. 3 at 2-5. The study was a census and not a representative sample. *Id.* at 2-9. Specifically, the authors warned that "conclusions must be drawn very cautiously because of the possibility of biased data." *Id.* at 2-3. Also, the authors acknowledged the limitation of the study due to the exlusion of self-insurers. *Id.*

Other weaknesses in the study were documented in the author's summary. Administrative Record Vol. 4, Tab 37. Because of the sample design, the authors concluded that it was "virtually impossible to generalize beyond the sample to annual totals or to national totals . . ." and that there was "no assurance that the sample was in any way representative of hospitals, of physicians, of injuries of geographic regions, of claimants." *Id.* While the plaintiffs' criticisms of the statistical validity of Westat study go far beyond those listed above, we do not address them as those heretofore discussed are sufficient for our decision.

(B) Procedural Challenges

Plaintiffs challenge the malpractice rule both procedurally and substantively. The procedural challenges are based upon the Administrative Procedure Act, Title 5 U.S.C. §§ 551 *et seq.*, §§ 701 *et seq.* The standard for judicial review of the validity of an administrative regulation is whether the Secretary complied with the necessary procedural requirements in promulgating the rule, whether the Secretary acted within the scope of her statutory power, and whether the choice was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). *See Citizens to Preserve Overton Park, Inc. v. Volpe,* 401 U.S. 402, 416-17 (1971). However, the "court is not empowered to substitute its judgment for that of the agency." *Id.* at 416. Nevertheless, judicial deference to the agency's judgment in implementing congressionally enacted statutory policies "cannot be allowed to slip into judicial inertia." *Bureau of Alcohol, Tobacco and Firearms v. Federal Labor Relations Authority,* 104 S. Ct. 439, 444 (1983), (quoting *American Ship Building Co. v. N.L.R.B.*, 380 U.S. 300, 318 (1965)), and Courts "are not obliged to stand aside and rubber stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute." *NLRB v. Brown,* 380 U.S. 278, 291 (1965). Finally, "if Congress established a presumption from which judicial review should start, that presumption . . . [is] *against* changes in current policy that are not justified by the rule making record." *Motor Vehicle Manufacturer's Ass'n of the United States, Inc. v. State Farm Automobile Insurance Company,* 103 S. Ct. 2856, 2866 (1983) (emphasis in original). Such is the standard as set forth by Judge Will in *St. James Hospital v. Heckler,* slip op. 83 C2773 at 11-12 (N.D. Ill. Jan. 27, 1984) with which we concur.

1. *Adequacy of the NPRM*

We first address the adequacy of the NPRM. The APA requires public notice of an agency's intention to issue a regulation. A notice must be "sufficient to fairly apprise interested parties of all significant subjects and issues involved." *American Iron and Steel Institute v. EPA,* 568 F.d 284, 291 (3d Cir. 1977), (citing S. Rep. No. 752, 79th Cong., 1st Sess. at 16 (1945)). Notice provisions are intended to provide the opportunity for public participation in the rule making process, *Buckeye Power, Inc. v. EPA,* 481 F.2d 162, 170 (6th Cir. 1973), *cert. denied, sub nom. Tennessee Valley Authority v. EPA,* 425 U.S. 934 (1976), and to inspire agency self-education prior to actual rule making. *American Iron,* 568 F.2d at 291. Notice is also valuable because it develops the record of agency decision-making and hence facilitates judicial review. *Home Box Office, Inc. v. FCC,* 567 F.2d 9, 35 (D.C. Cir. 1977), *cert. denied,* 434 U.S. 829 (1977). Notice is most valuable when it discloses the data upon which the agency proposes the rule. *Connecticut Light and Power Company v. Nuclear Regulatory Commission,* 673 F.2d 525, 530-31 (D.C. Cir.), *cert. denied,* 459 U.S. 835 (1982). *Cf. United States Lines v. Federal Maritime Commission,* 584 F.2d 519 (D.C. Cir. 1978).

From examination of the NPRM at issue here, the agency is in technical non-compliance because of the failure to identify the data upon which it relied—(*i.e.*, the Westat study or any other data for that matter). However, the rule making record indicates that the Westat study reached health care professionals in sufficient number in time to permit development of the rule making record. The Westat study is discussed in detail in the rule making record, and therefore, we will not declare the rule invalid because of this technical non-compliance.

2. *Adequacy of the basis and purpose statement*

We turn next to the adequacy of the basis and purpose statement which accompanied the rule in its final form. A basis and purpose statement is required by 5 U.S.C. § 553(c). *Sierra Club v. Gorsuch*, 715 F.2d 653, 658 n.31 (D.C. Cir. 1983). Section 553(c) provides in pertinent part:

> After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose.

The basis and purpose statement need not be an exhaustive discussion of comments to the agency. *Automotive Parts and Accessories Ass'n v. Boyd*, 407 F.2d 330, 338 (D.C. Cir. 1968). However, the agency must "respond in a reasoned manner to the comments received, to explain how the agency resolved any significant problems raised by the comments, and to show how that resolution lead the agency to the ultimate action." *Action on Smoking and Health v. C.A.B.*, 699 F.2d 1209, 1216 (D.C. Cir. 1983) (quoting *Rodway v. U.S. Department of Agriculture*, 514 F.2d 809, 817 (D.C. Cir. 1975)). Ultimately, "the detail required in a statement of the basis and purpose depends upon the subject of regulation and the nature of the comments received." *Action on Smoking and Health*, 699 F.d at 1216.

In the instant case, the subject of regulation is a rule by which health care providers are reimbursed for malpractice insurance costs. This regulation has considerable economic impact and represents a significant change from previous agency policy. While we do not question the Secretary's authority to depart radically from existing policy, we note that there is a presumption against such

changes, unless they are supported by the rule making record. *Motor Vehicle Manufacturers*, 103 S. Ct. at 2866. This presumption requires the Secretary or Agency to respond in significant detail to serious comments opposing the proposed regulations. Here, we do not view the agency's response as sufficient. On this point we agree with Judge Fullam of the Eastern District of Pennsylvania who stated:

> It would have been a miracle of bureaucratic succinctness had the Secretary managed to reply adequately in two scant columns of Federal Register prose to the six hundred plus comments that occupy five thick volumes of the administrative record. Unfortunately no such miracle has been witnessed by this court.

Abington Memorial Hospital v. Heckler, 576 F. Supp. 1081, 1085-86 (E.D.P.A. 1983) *aff'd* 750 F.2d 242 (3d Cir. 1984).

More disturbing than the brevity of the basis and purpose statement is the content. As Judge Fullam noted, the American Hospital Association and the Hospital Corporation of America, among other commenters, questioned the statistical validity of the Westat study which was the only objective data upon which the regulation was based. *See* Administrative Record Vol. 5, (no tab) p. 9; and Vol. 6 (no tab) p. 5. The preamble to the final rule neither acknowledges nor responds to these criticisms. *See* 576 F. Supp. 1086. Again, as noted by Judge Fullam, the comments included contentions that malpractice insurance costs were not necessarily reflected by claims payments, however, these comments were not addressed by the agency in promulgating the final rule either. *Id.*

In sum, we conclude that the agency has neither responded in a reasoned manner to comments received nor explained how it resolved significant problems raised by these comments. Rather, we are left with the impression that the agency evaded the most significant problems

raised by the comments, *i.e.*, the statistical challenges to the Westat study and the use of the Westat study for purposes other than those for which it was intended. The conclusion is inescapable that the agency violated the APA in failing to include an adequate basis and purpose statement with the regulation in its final form.

3. *Abuse of Discretion*

Plaintiffs also challenge the new malpractice rule under 5 U.S.C. § 706(2)(A). That statute provides that a reviewing court may set aside agency action when found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." *Id.* In short, plaintiffs contend that the Secretary's action in promulgating the new malpractice rule was arbitrary and capricious. The standard of review under section 706(2)(a) has recently been stated as "whether the decision was based upon a consideration of the relevant factors and whether there had been a clear error of judgment." *Motor Vehicle Manufacturers Ass'n,* 103 S. Ct. 2856, 2865, 2867 (1983). The reviewing court should not second guess the agency on technical matters but should "set aside administrative rules for which the record . . . demonstrates a lack of rational basis." *PPG Industries v. Costle,* 630 F.2d 462, 465 (6th Cir. 1980). Reliance on flawed data is properly considered a clear error in judgment at least where the flaws are known to the agency prior to promulgation of the final rule. *Almay, Inc. v. Califano,* 569 F.2d 674 (D.C. Cir. 1977).

In this case we think it is clear that the Secretary relied on flawed data in promulgating the new malpractice rule. The authors of the Westat report stated that "conclusions must be drawn very cautiously because of the possibility of biased data." Administrative Record Vol. 3 at 2-2. Also, in a memorandum to the HEW project officer in charge of the medical malpractice study, the Westat senior analyst stated that it is "virtually impossible to generalize beyond

the sample . . . to annual totals or to national totals. . . ." Beyond that there was no assurance that the sample was in any way representative of [hospitals], of physicians, of injuries, of geographic regions, of claimants. Administrative Record Vol. 4, Tab 37. Given these comments by the authors and the fact that the Secretary then used the Westat study as a basis for implementing the regulation, and, extrapolated from the study the "national average" of 5.1%, it is abundantly clear that the agency proceeded to use the Westat study in the very manner the authors cautioned against. Under such circumstances we have no hesitation in holding the implementation of the new Medicare malpractice reimbursement rule a clear error of judgment.

(C) Substantive Challenge

We do not decide whether the new malpractice rule is in violation of the substantive provisions of the Medicare Act as plaintiffs contend. As the procedural issues are dispositive, it is unnecessary for us to reach this issue. Furthermore, we do not presume to determine any inconsistency based on what we view as the significantly flawed factual basis upon which the agency premised the challenged rule.

IV. CONCLUSION

We recognize that deferential consideration should be given regulations promulgated by the Secretary, and that courts should be cautious to overturn such regulations. *NLRB v. Bell Aerospace Co. Division of Textron, Inc.,* 416 U.S. 267, 274-75 (1974). Having exercised that caution, we must nevertheless invalidate the regulation challenged in this action. We note that in holding the regulation invalid we are in accordance with the consid-

erable weight of authority.[2]

In accordance with the foregoing, plaintiffs' motion for summary judgment is hereby granted and defendant's

[2] The new Medicare Malpractice Reimbursement Rule has been invalidated in at least eighteen cases. *Arkansas Methodis Hospital v. Heckler*, Slip Op. J-C-83-106 (E.D. Ark. Nov. 2, 1984); *East Jefferson General Hospital v. Heckler*, Slip Op. 83-4107-C (E.D. La. Oct. 19, 1984); *St. Anthony Regional Hospital v. Heckler*, No. C84-37 (N.D. Iowa Oct. 12, 1984); *Parkway Medical Center v. Heckler*, Slip Op. 83-1700 (S.D. Fla. Sept. 24, 1984); *Mercy Medical Center v. Heckler*, No. 3-82 Civ. 1724 (D. Minn. Aug. 17, 1984); *Menorah Medical Center v. Heckler*, No. 83-0822-CV-W-4 (W.D. Mo. July 26, 1984); *Metropolitan Hospital, Inc. v. Heckler*, Slip Op. C-83-502-A (N.D. Ga. June 25, 1984); *DeSoto General Hospital v. Heckler*, Civil Action 83-1050-B (M.D. La. June 20, 1984); *Alexandria Hospital v. Heckler*, No. 83-0233-R (E.D. Va. May 4, 1984); *St. Joseph's Hospital, Tuscon v. Heckler*, Slip Op. 82-781 (D. Ariz. April 24, 1984); *Lloyd Noland Hospital and Clinic v. Heckler*, Slip Op. CV-83-PT-0868-S (N.D. Ala. April 5, 1984); *Bedford County Memorial Hospital v. Heckler*, Slip Op. 83-836-A (W.D. Va. March 28, 1984); *Humana of Illinois, Inc.*, Slip Op. 83-3061 (C.D. Ill. March 2, 1984), *appeal docketed*, No. 894-1727 (7th Cir. April 30, 1984); *Albany General Hospital v. Heckler*, Slip Op. 83-851-FR (D. Ore. March 2, 1984), *appeal docketed*, No. 84-3865 (9th Cir. June 6, 1984); *St. James Hospital v. Heckler*, Slip Op. 83C2773 (N.D. Ill. Jan. 27, 1984); *Chelsea Community Hospital v. Heckler*, Slip Op. 83 CV-6126-AA (E.D. Mich. Dec. 20, 1983); *Mt. Carmel Mercy Hospital v. Heckler*, Slip Op. 82-74193 (E.D. Mich. Nov. 30, 1983); *Abington Memorial Hospital v. Heckler*, 576 F. Supp. 1081 (E.D. Pa. 1983) *aff'd* 750 F.2d 252 (3d Cir. 1984).

To our knowledge, the malpractice rule has been upheld in four cases. *Humana of Aurora, Inc. v. Heckler*, No. 83-7-70 (D. Colo. Sept. 19, 1983), *rev'd and rem'd*, 753 F.2d 1579 (10th Cir. 1985); *Walter O. Boswell Memorial Hospital v. Heckler*, 573 F. Supp. 884 (D.D.C. 1983) *rev'd and rem'd*, slip op. 83-2223 (D.C. Cir. Nov. 30, 1984); *Cumberland Medical Center v. Heckler*, 578 F. Supp. 39 (M.D. Tenn. 1983) *appeal docketed*, No. 83-5549 (6th Cir. Aug. 9, 1983); *Athens Community Hospital v. Heckler*, 565 F. Supp. 695 (C.D. Tenn. 1983), *appeal docketed*, No. 83-5546 (6th Cir. Aug. 5, 1983). As reflected by the subsequent history above, two of these four cases have been reversed and remanded.

motion for summary judgment is hereby denied. The parties will brief the issues of the appropriateness of relief according to the normal briefing schedule set out by the local rules of this Court. Plaintiffs' brief is due within thirty days of the date of this Order.

SO ORDERED.

/s/ S. ARTHUR SPIEGEL

S. Arthur Spiegel
United States District Judge

Department of Health and Human Services
Provider Reimbursement Review Board
793 Elkridge Landing Road
Linthicum, Maryland 21090

Refer to:
JB:81-229G
FEB. 18, 1983
Certified Mail

Location:
Airport Investment Building
Room 245, South Plaza
Telephone: 301-859-5820

Margaret Manning, Esquire
Ober, Grimes & Shriver
1600 Maryland National Bank Building
Baltimore, Maryland 21202

Dear Ms. Manning:

Re: Ohio Malpractice Group Appeal, Case No. 81-229G

The Board has reviewed the record in the above-captioned case and finds there is no jurisdictional authority concerning the malpractice issue for the providers listed on the enclosure in the Ohio Malpractice Group Appeal. This finding is based upon the fact that the malpractice issue was not raised in the Prover's cost report(s); nor have any amended cost report(s) been accepted by the Intermediary on this issue; nor have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue.

Pursuant to the controlling law and regulations (42 USC section 1395oo and 42 CFR 405, subpart R), the Board is empowered to review and hold hearings concerning final determinations of fiscal intermediaries (i.e., NPR) regarding Medicare provider cost reimbursement. The jurisdictional requirements to secure a Board hearing are set forth in 42 USC section 1395oo(a) and (b).

Title 42 USC section 1395oo provides:

> "(a) *Any provider of services which has filed a required cost report* within the time specified in regulations *may obtain a hearing with respect to such cost*

> report by a Provider Reimbursement Review Board (hereinafter referred to as the 'Board') which shall be established by the Secretary in accordance with subsection (h), *if*–
>
> (1) such provider –
>
> (A) *is dissatisfied with a final determination* of the organization serving as *its fiscal intermediary* . . . as to the amount of total program reimmbursement due the provider for the period *covered by such report*, . . .
>
> (2) the *amount in controversy* is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination. . . .
>
> (b) The provisions of subsection (a) shall apply to any group . . . if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more." (Emphasis added)

The regulation, 42 CFR 405.1839(a), provides the methodology of determining the $10,000 amount in controversy as follows:

> "The $10,000 *amount in controversy* will be computed by deducting the adjusted total reimbursable program costs from the total reimbursable cost . . . *claimed* by the provider." (Emphasis added)

The cited statutory provisions clearly entitle a provider to a Board hearing only with respect to a cost report which was filed in compliance with the rules and regulations of the Secretary. The Board's jurisdiction is limited to issues when the provider ". . . is dissatisfied with a final determination (NPR) of its intermediary . . ." on matters covered by such filed cost report; and the request for hearing is made within 180 days of the NPR. The statutory phrases ". . . dissatisfied with a final determination of its

intermediary . . .", ". . . amount in controversy . . .", and ". . . covered by such cost report . . ." certainly indicate that a provider must have made an overt disclosure (notice) of its posture on a particular issue which ordinarily would be evidenced by claiming reimbursement for the particular item on the cost report.

The regulations clearly require that, as a condition precedent, the provider must have claimed the cost in its filed cost report to give rise to any controversy. Without any notice of a claimed cost on a cost report, the intermediary is precluded from considering the matter and making any final determination for that particular item which especially applies to self-disallowed costs. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction. Thus, the Board's jurisdiction flows from the intermediary's NPR with respect to the filed cost report, and the disputes arising from costs claimed in the cost report.

The provider's entitlement to a hearing is conditioned upon the three subsections immediately following the word "IF" of the basic section—see 42 USC 1395oo(a) cited above. Accordingly, the statutory language *does require* dissatisfaction with the intermediary's final determination and for a controversy to exist. When the provider files a cost report, the particular cost must be claimed therein or state its claim and disclose its position on an issue so the intermediary can consider and make a final determination which was not done in this case. This is essential to Board jurisdiction.

The statute does not entitle a provider to claim additional reimbursement for a particular cost reporting period after filing its cost report nor after receiving the intermediary's final determination (NPR). However, once a cost report is filed, the regulations provide that any amendments to the cost report ". . . may be permitted or required as determined by the Health Care Financing Administration, ..." (42 CFR section 405.453(f)) HCFA

policy instructions stated in Pt. 2—Part A Intermediary Manual, section 2631.2 (HIM-13-2), contains the criteria in the limited situations where the intermediary may accept an amended cost report. Once an intermediary has issued a final determination (NPR) regarding a provider's filed cost report, a cost report may only be amended if the intermediary "reopens" its final determination. Accordingly, the reopening provisions of the regulations are controlling, 42 CFR section 405.1885(a), and jurisdiction for such reopenings rests exclusively with that administrative body that rendered the last determination (which in this case was the intermediary) (42 CFR section 405.1885(c)). (See *Athens Community Hospital, Inc., et. al., v. Richard S. Schweiker, Secretary of Health and Human Services,* United States Court of Appeals for the District of Columbia Circuit, No. 81-1807, August 27, 1982.)

The Athens court (supra) stated:

> "Reopening is thus allowed only to hear new evidence—not new claims. Moreover, under 42 CFR section 405.1885(c), jurisdiction to reopen "rests exclusively with that administrative body that rendered the last determination or decision"; in other words, if the fiscal intermediary decides not to reopen, the decision is not appealable to the PRRB."

Section 405.1885(c) of the regulations states that ". . . jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." Section 405.453(f) also provides that ". . . amended cost report information which has been previously submitted by a provider *may be permitted* or required as determined by the Health Care Financing Administration." The Medicare Bureau's (formerly Bureau of Health Insurance) policy (HIM 13, Part 2) further adds "Whether or not the Intermediary will reopen a determination . . . which is otherwise final, will depend upon whether new and material

evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations, or guidelines."

The above authorities provide: (1) that the acceptance of an amended cost report is within the discretion of the intermediary, and (2) that once an NPR has been issued, then the reopening (including through an amended cost report) is within the exclusive jurisdiction of the intermediary which is not appealable per se.

The Board's jurisdiction flows from the cost report or amended cost report and the related NPR or revised NPR. There must have been a claim on the cost report or amended cost report that ultimately gives rise to the disagreement. Thus, Board jurisdiction is limited to those cases in which a provider has claimed a reimbursement amount and the intermediary has denied that claim in full or in part. Title 42 USC 1395oo(d) provides:

> "The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make other revisions on matters *covered by such cost report* (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination."

The Athens Court stated:

> "This provision is clearly limited to revisions of matters covered by the original cost report and does not authorize the Board to consider new claims. Such a conclusion is reinforced by 42 USC section 1395oo(a) which similarly limits PRRB review to matters raised by the original cost report."
>
> "Nor do the Medicare regulations provide a basis for such review. The language in 42 CFR section 405.1869 is virtually identical to that in 42 USC section 1395oo(d) . . . and the scope of the regulation is accordingly limited to 'matters covered by (the original) cost report.' "

It is equally clear, therefore, that the Board, in reaching a decision, may go beyond just the matters which were considered by the intermediary in making its final determination but that such expansion is limited to "matters covered by such cost report." A number of providers have asked that they be allowed to introduce into Board hearings various additional reimbursement items which they had never claimed and which their intermediaries had, therefore, never adjusted or disallowed. Neither the law nor the Board's exercise of this section 1395oo(d) authority in limited cases contemplated any substantial proliferation. No consideration will be given to any request for a hearing which does not comply with the foregoing minimal requirements and no expansion of the scope of the appeal or the hearing will be allowed to include any other issue or amount not originally claimed. This determination is subject to the provisions of 42 USC 1395oo(f).

Board Members Participating:

Thomas M. Tierney
James Houdek, Jr., CPA
Bette A. Kraus
Paul Morton Ganeles, CPA
Richard A. Dudgeon, CPA

FOR THE BOARD:

/s/ THOMAS M. TIERNEY
Thomas M. Tierney
Chairman

Enclosure

cc:
Irwin Cohen, Esquire, Attorney Advisor's Office
Mr. John P. Ruocco, Blue Cross and Blue Shield Ass'n.
Mr. Louis C. Schwienher, Hospital Care Corporation
Mr. Vito Checchio, Blue Cross of Central Ohio
Mr. Donald L. Reed, Blue Cross of Northwest Ohio
Mr. Edward S. Shamrock, Blue Cross of Northeast Ohio

ISSUE: COSTS OF MALPRACTICE INSURANCE

Number	Provider Name	Date of NPR	Date of Hearing Request	Cost Reporting Period-FYE	Fiscal Intermediary	Amount of Medicare Reimbursement In Controversy	Audit Adjustment Number
36-0193	Bethesda Hospital	04/28/82	09/09/82	12/31/80	Blue Cross of Central Ohio	141,381	
36-0127	Memorial Hospital of Geneva	05/21/82	08/20/82	12/31/80	Blue Cross of N.E. Ohio	9,000	•
36-0021	St. Joseph River-side Hospital	02/19/82	01/19/83••	12/31/80	Hospital Care Corporation	[2,035]	•
36-0145	Elyria Memorial Hospital	04/23/82	09/09/82	12/31/80	Blue Cross of N.E. Ohio	16,752	•
36-0038	Deaconess Hosp.	06/29/82	01/19/83	12/31/80	Hospital Care Corporation	61,970	•

Supreme Court, U.S.
FILED
AUG 17 1987
JOSEPH F. SPANIOL, JR.
CLERK

No. 86-1764

In the Supreme Court of the United States

OCTOBER TERM, 1987

BETHESDA HOSPITAL ASSOCIATION, ET AL., PETITIONERS

v.

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE RESPONDENT

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RICHARD K. WILLARD
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QUESTION PRESENTED

Whether the Provider Reimbursement Review Board may consider a health care provider's claim that it is entitled to reimbursement under the Medicare statute for a particular cost when the provider failed to seek reimbursement for that cost from its fiscal intermediary and did not otherwise reserve before the intermediary its right to seek reimbursement for that cost.

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In the Supreme Court of the United States

OCTOBER TERM, 1987

No. 86-1764

BETHESDA HOSPITAL ASSOCIATION, ET AL., PETITIONERS

v.

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE RESPONDENT

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-8a) is reported at 810 F.2d 558. The opinion of the district court (Pet. App. 29a-51a) is reported at 609 F. Supp. 1360. The opinion of the Provider Reimbursement Review Board (Pet. App. 52a-58a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on February 2, 1987. The petition for a writ of certiorari was filed on May 2, 1987. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. At the time of the events at issue in this case, all "providers" of health care services to Medicare beneficiaries were reimbursed by the Secretary of Health and Human Services on an annual basis for the "reasonable cost" of those health care services. 42 U.S.C. (& Supp. III) 1395f(b), 1395x(u) and (v)(1)(A).[1] Over the course of the year, the Secretary made payments to a provider based upon an estimate of the amounts owed to the provider. 42 U.S.C. (& Supp. III) 1395g; 42 C.F.R. 413.60. At the end of the year, the provider submitted a claim for reimbursement in the form of a "cost report." See 42 U.S.C. (& Supp. III) 1395f(a); 42 C.F.R. 413.20(a) and (b), 413.24(f).[2] The cost report is "a lengthy document consisting of numerous schedules, worksheets, and supplemental worksheets. * * * [A] cost report, when completed, is approximately three-quarters of an inch thick" (*Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d 1, 3 (D.C. Cir. 1984)). Providers list on the worksheets cost items for which they do not seek reimbursement because those cost items supply background information that supports the provider's cost claims.

The cost report is submitted to the provider's "fiscal intermediary" for review.[3] The intermediary

[1] These cases concern payments under "Part A" of the Medicare statute, which provides coverage for "the costs of hospital, related post-hospital, home health services, and hospice care" (42 U.S.C. 1395c).

[2] The report is due three months after the end of the provider's fiscal year. The provider may obtain a 30-day extension of the due date for "good cause." 42 C.F.R. 413.24(f)(2).

[3] The intermediary, which is generally a private insurance company, is an entity that, pursuant to a contract with the Secretary, acts as the Secretary's agent in reviewing the provider's claims and determining the amount of reimbursement owed to the provider. See 42 U.S.C. (& Supp. III) 1395h; 42 C.F.R. 421.3, 421.100-421.128.

audits the cost report and issues a Notice of Program Reimbursement specifying the total amount of reimbursement due to the provider and explaining any adjustments to the costs claimed by the provider. See 42 C.F.R. 405.1803.[4]

If a provider has timely filed its cost report and is "dissatisfied with [the intermediary's] final determination * * * as to the amount of total program reimbursement due the provider" or has not received a final determination on a "timely basis," the provider "may obtain a hearing with respect to such cost report" before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. (& Supp. III) 1395*oo*(a)(1); see also 42 C.F.R. 405.1835.[5] The PRRB is authorized by statute (42 U.S.C. 1395*oo*(d)) to

> affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

[4] The reimbursement award specified in the Notice of Program Reimbursement is compared to the Secretary's payments to the provider. Any deficiency is paid by the Secretary and any overpayment is repaid by the provider. 42 C.F.R. 405.1803(c), 413.60.

[5] Review by the PRRB is available only if the amount in controversy is $10,000 or more and the provider's request for a hearing is timely filed (42 U.SC. (& Supp. III) 1395*oo*(a)(2) and (3)).

The Board's decision is final unless the Secretary reverses, affirms, or modifies the decision within 60 days. The Board's decision—or the Secretary's modified decision, if any—is subject to judicial review in federal district court pursuant to the Administrative Procedure Act. 42 U.S.C. (& Supp. III) 1395*oo* (f) (1)); 42 C.F.R. 405.1875-405.1877.

The statute establishes a second, more expeditious route into court in certain circumstances. A provider may obtain direct judicial review of "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines * * * that it is without authority to decide the question." 42 U.S.C. (& Supp. III) 1395*oo*(f)(1); see also 42 C.F.R. 405.1842.[6]

2. Petitioners are two hospitals that have been certified as providers of services under the Medicare program. In their cost reports for 1980 and 1981 petitioners computed their claims for malpractice insurance premium reimbursement in accordance with the regulation governing reimbursement for such costs. As the court of appeals observed, "[t]he hospitals' cost reports thus included a claim for reimbursement for malpractice insurance costs, but * * * effectuated a 'self-disallowance' " of such malpractice insurance costs in excess of those allowed under the 1979 Rule. Because these hospitals complied with the Secretary's regulation and cost report instructions, there was no need for the fiscal intermediary reviewing their cost reports to make an audit adjustment

[6] A final decision may be reopened by the intermediary, the Board, or the Secretary in certain circumstances. See 42 C.F.R. 405.1885.

with respect to the malpractice insurance issue before issuing a Notice of Program Reimbursement" (Pet. App. 5a).

Together with more than 25 other Ohio hospitals, petitioners filed an appeal with the Provider Reimbursement Review Board challenging the regulation governing the reimbursement of medical malpractice insurance premiums. The Board found that it lacked jurisdiction over petitioners' claims because "the malpractice issue was not raised in the * * * cost report(s); nor have any amended cost report(s) been accepted by the intermediary on this issue; nor have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue" (Pet. App. 52a). The Board stated that "the provider must have claimed the cost in its filed cost report to give rise to any controversy. Without any notice of a claimed cost on a cost report, the intermediary is precluded from considering the matter and making any final determination for that particular item * * *. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction" (*id.* at 54a). Thus, "[w]hen the provider files a cost report, the particular cost must be claimed therein or [the provider must] state its claim and disclose its position on an issue which was not done in this case" (*ibid.*).[7]

Petitioners sought judicial review of the Board's determination, and the district court reversed (Pet.

[7] The Board permitted the hospitals that had raised the issue before the intermediary to seek direct judicial review of their challenge to the malpractice insurance cost reimbursment, finding that the Board lacked authority to decide the hospitals' claim that the regulation governing reimbursement was invalid (see 42 U.S.C. (& Supp. III) 1395*oo*(f)(1)).

App. 29a-51a). It concluded that the Board's review of the intermediary's determination "need not be limited to costs claimed by the provider to the intermediary in the cost report" (*id.* at 34a).[8]

3. The court of appeals, in turn, reversed the district court's decision. Relying upon its prior decision in *Baptist Hospital East* v. *Secretary of Health & Human Services*, 802 F.2d 860 (1986), the court concluded that the Board lacks jurisdiction over "claims by providers who * * * self-disallowed reimbursement and * * * failed to challenge the Secretary's regulations before the fiscal intermediary" (Pet. App. 6a). The *Baptist Hospital East* court had observed that the contrary interpretation of the statute —permitting the Board to act where the provider did not claim reimbursement—"renders the second part of the jurisdictional grant meaningless" and "places an irrational gloss on the statute" (802 F.2d at 865). The construction of the statute adopted by the court instead requires a provider "to present a coherent claim for reimbursement at the time it files its cost report. It may not present claims to its intermediary, await the intermediary's decision, and then decide based upon its success before the intermediary whether to raise additional claims before the Board" (*ibid.*).[9]

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[8] The district court also invalidated the malpractice insurance cost reimbursement rule (Pet. App. 42a-59a).

[9] The court of appeals rejected petitioners' claim that a contrary result was required by this Court's decision in *Bowen* v. *Michigan Academy*, No. 85-225 (June 9, 1986). It observed that *Michigan Academy* "dealt only with the right to judicial review in the absence of meaningful administrative review procedures" (Pet. App. 6a). Here, by contrast, there is an administrative review scheme, and the issue is whether

ARGUMENT

The court below correctly concluded that the Provider Reimbursement Review Board lacks authority to consider reimbursement claims that are not raised before the fiscal intermediary, such as the claims advanced by petitioners here. We believe this Court should grant certiorari, however, because the petition presents a question of considerable importance to the administration of the Medicare program as to which there is a square conflict among the courts of appeals.[10]

1. The Medicare statute contains two grants of authority empowering the Provider Reimbursement Review Board to revise the amount of reimbursement awarded to a provider by its fiscal intermediary. First, the Board has "the power to affirm, modify or reverse a final determination of the fiscal intermediary with respect to a cost report" (42 U.S.C. 1395*oo*(d)). Second, it may "make any other revisions on matters covered by such cost report (includ-

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"the *steps* in [the administrative review] process * * * include submission of a 'claim' before the fiscal intermediary as a prerequisite to PRRB and judicial review, in essence an exhaustion requirement" (*id.* at 7a (emphasis in original)).

With regard to the challenge to the malpractice reimbursement rule advanced by the hospitals that had properly preserved the issue, the court held that a newly-promulgated rule governing malpractice cost reimbursement could not be applied retroactively to the cost years at issue in this case. It therefore upheld the district court's award of additional reimbursement to these hospitals. Pet. App. 3a-4a.

[10] The same question is also presented in two other cases pending before the Court. See *North Broward Hospital District* v. *Bowen*, petition for cert. pending, No. 86-1986; *University of Cincinnati* v. *Secretary of Health & Human Services*, petition for cert. pending, No. 87-57.

ing revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making [its] final determination" (*ibid.*). The Secretary has concluded that these provisions authorize the Board to act upon a provider's claim for reimbursement only if the provider sought reimbursement for the particular cost before the intermediary or otherwise raised before the intermediary its contention regarding the reimbursability of the cost. See Pet. App. 54a; *Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d 1, 8 (D.C. Cir. 1984). That interpretation of the PRRB's jurisdiction is eminently reasonable.

As a threshold matter, it is instructive to consider the other possible interpretations of the scope of the Board's statutory authority. The Board could be free to consider any cost reimbursement claim advanced by a provider, without regard to whether the cost was even mentioned in the provider's cost report. But the statute expressly states that the Board may only revise the intermediary's determinations "with respect to a cost report" and may only act with respect to other "matters covered by such cost report." An interpretation of the statute that made the contents of the cost report irrelevant would "effectively nullify the language in the statute that limits the PRRB's authority to affirm, reverse or modify reimbursements to 'matters covered by [a] cost report.'" *Community Hospital* v. *Health & Human Services*, 770 F.2d 1257, 1262 (4th Cir. 1985) (quoting *Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d at 6).

The second possible interpretation of the statute would be to permit the Board to consider a provider's claim for reimbursement with respect to all cost

items disclosed to the intermediary in the cost report, even if the provider did not seek reimbursement for the particular costs. We submit that, for three basic reasons, the court below was correct in rejecting this interpretation of the statute and upholding the Secretary's view of the Board's jurisdiction. Pet. App. 5a-6a, 7a; see also *Community Hospital* v. *Health & Human Services*, 770 F.2d at 1262-1263; *North Broward Hospital District* v. *Bowen*, 808 F.2d 1405, 1408-1410 (11th Cir. 1987), petition for cert. pending, No. 86-1986; *Athens Community Hospital, Inc.* v. *Schweiker*, *supra*.

First, the Secretary's interpretation gives effect to both statutory grants of jurisdiction. If the Board's authority to act with regard to "matters covered by [a] cost report" were found to allow it to consider any claim for reimbursement—including claims not presented to the intermediary—then the grant of authority to review the intermediary's determinations respecting the cost report would be completely superfluous. It is much more logical to interpret the statute

> as allowing the PRRB to revise aspects of the reimbursement calculation not actually contested by the provider, and possibly not considered by the intermediary (because not claimed for reimbursement by the provider), [only] when such revision is necessary to accommodate other PRRB revisions of matters that were claimed by the provider, decided adversely by the intermediary, and then contested by the provider to the PRRB.

Athens Community Hospital, Inc., 743 F.2d at 9; see also *North Broward Hospital District* v. *Bowen*, 808 F.2d at 1409; *Community Hospital* v. *Health & Human Services*, 770 F.2d at 1262.

Second, the Secretary's interpretation of the statute best comports with the rest of the statutory scheme. A provider may "obtain a hearing" before the PRRB if it is "dissatisfied with a final determination of the * * * fiscal intermediary" (42 U.S.C. (& Supp. III) 1395*oo*(a)). "It would be anomalous * * * to say that a provider can appeal only when 'dissatisfied' while allowing the provider to obtain review of an intermediary's refusal to reimburse the provider for a cost it did not even claim. * * * If a provider is unhappy with the reimbursement the intermediary allowed in such a case, it is the fault of the provider and not of the intermediary." *Athens Community Hospital, Inc.*, 743 F.2d at 6; see also *North Broward Hospital District*, 808 F.2d at 1409. Indeed, Congress indicated in other parts of the statute that the provider's presentation of its claim to the intermediary is an essential prerequisite to further review. See 42 U.S.C. (& Supp. III) 1395*oo*(f)(1) (emphasis added) (authorizing provider to obtain direct judicial review of "*any action of the fiscal intermediary* which involves a question of law or regulations" that the Board lacks authority to decide).

Third, allowing the provider to raise a reimbursement claim for the first time before the PRRB "would have significant adverse practical consequences" (*Athens Community Hospital, Inc.*, 743 F.2d at 6). If a provider revised its claim *after* the intermediary's issuance of the Notice of Program Reimbursement, it would " 'deprive [the PRRB] of the intermediary's analysis and conclusions and make the PRRB the tribunal of original jurisdiction, eliminating a tier of review, and [have the effect of] possibly substantially slowing the reimbursement process for other providers.' " *Id.* at 6-7 (citation omitted); see also

North Broward Hospital District v. *Bowen*, 808 F.2d at 1409 (allowing provider to seek review of costs not claimed before the PRRB "would result in the elimination of the administrative review process clearly provided for in the Medicare statute and regulations); *Baptist Hospital East* v. *Secretary of Health & Human Services*, 802 F.2d at 865 (provider "may not present claims to its intermediary, await the intermediary's decision, and then decide based upon its success before the intermediary whether to raise additional claims before the Board").

For these reasons, "a provider, to retain the right to appeal the decision on whether a cost is reimbursable, must either expressly request reimbursement for a cost item in its initial cost report or specifically contest the non-allowability of the item with its intermediary in or with the cost report" (*North Broward Hospital District*, 808 F.2d at 1409-1410 (footnote omitted)).[11]

2. There is a square conflict among the courts of appeals regarding the question presented in this case. Three courts of appeals, including the court below, have concluded that the Provider Reimbursement Review Board has jurisdiction only "over costs that are specifically claimed [in the cost report] * * * as well

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[11] Petitioners argue (Pet. 11-12) that this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, No. 85-225 (June 9, 1986), supports their position. The Court held in that case that a statutory provision precluding judicial review of benefits determinations did not bar review of regulations governing the method by which those determinations are made. There is no claim here that judicial review is precluded. Instead, the question relates to the procedures governing the availability of review; specifically, whether a provider must raise its claims before the fiscal intermediary in the first instance. *Michigan Academy* is wholly inapposite.

as those cost issues [explicitly] raised by a provider prior to the intermediary's issuance of the [Notice of Program Reimbursement]." *Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d 1, 5-6 (D.C. Cir. 1984); *Baptist Hospital East* v. *Secretary of Health & Human Services*, 802 F.2d 860, 865-866 (6th Cir. 1986); *Community Hospital* v. *Health & Human Services*, 770 F.2d 1257, 1262 (4th Cir. 1985).

Two courts of appeals have concluded that a health care provider may seek administrative and judicial review of a cost item identified, but not claimed, in its cost report. *Adams House Health Care* v. *Heckler*, 817 F.2d 587 (9th Cir. 1987); *St. Mary of Nazareth Hospital Center* v. *Department of Health & Human Services*, 698 F.2d 1337, 1346 (7th Cir.), cert. denied, 464 U.S. 830 (1983). The First Circuit has concluded that "the [PRRB] has the legal power to decide matters not raised" before the intermediary but that, as a matter of administrative discretion, "it is up to the [PRRB] in the first instance to decide whether it will not hear the * * * claim." *St. Luke's Hospital* v. *Secretary of Health & Human Services*, 810 F.2d 325, 330, 332 (1987).

Two panels of the Eleventh Circuit that have considered the question have reached somewhat conflicting conclusions. In *North Broward Hospital District* v. *Bowen*, 808 F.2d 1405 (11th Cir. 1987), petition for cert. pending, No. 86-1986, the court held that "a provider, to retain the right to appeal the decision on whether a cost is reimbursable, must either expressly request reimbursement for a cost item in its initial cost report or specifically contest the non-allowability of the item with its intermediary in or with the cost report" (808 F.2d at 1409-1410 (footnote omitted)). In *Tallahassee Memorial Regional Medical Center* v. *Bowen*, No. 85-3839 (11th Cir. May 5, 1987), on the other hand, the court concluded that a provider may seek judicial review of the failure to award such costs at least where the award of the costs is barred by regulation, on the ground that such a claim falls within the statutory provision permitting judicial review of questions of law that the PRRB lacks authority to decide.

3. Although recent amendments to the Medicare statute have reduced somewhat the importance of the issue regarding the scope of the PRRB's jurisdiction that is presented in this case, the matter remains sufficiently important to warrant review by this Court.

Most hospitals are no longer reimbursed for inpatient services to Medicare beneficiaries solely on the basis of the "reasonable cost" incurred in providing services to Medicare patients. In Title VI of the Social Security Amendments of 1983, Pub. L. No. 98-21, §§ 601-607, 97 Stat. 149-172, Congress adopted the prospective payment system (PPS). Under PPS (which has been implemented over a four-year transition period beginning on October 1, 1983), hospitals are paid predetermined rates for specific services, regardless of the costs incurred by the hospital in providing those services. See 42 U.S.C. (& Supp. III) 1395ww(d), as amended by Pub. L. No. 99-272, § 9102, 100 Stat. 155. Congress adopted PPS primarily "to reform the financial incentives hospitals face, promoting efficiency in the provision of services by rewarding cost/effective hospital practices" (H.R. Rep. 98-25, 98th Cong., 1st Sess. 132 (1983)).

Many Medicare providers are not covered by the prospective payment system, however, and continue to obtain reimbursement for their "reasonable" costs by filing cost reports. See 42 C.F.R. 412.20-412.32

(rehabilitation hospitals, psychiatric hospitals, children's hospitals, and hospitals with average length of stay greater than 25 days are not covered by PPS), 413.1 (reasonable cost payment system applies to skilled nursing facilities, home health agencies, and other facilities providing services other than in-hospital care). Moreover, all providers are reimbursed for some categories of costs on a reasonable cost basis. See, *e.g.*, 42 U.S.C. (& Supp. III) 1395ww (a)(4) (anesthesia services provided by nurse); 42 C.F.R. 412.2(d) (capital costs, direct medical education costs, costs for direct medical and surgical services provided by certain physicians in teaching hospitals).[12] Thus, the question presented here regarding the scope of the Board's jurisdiction is a matter of considerable continuing importance.[13]

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[12] In addition, many disputes concerning hospitals' claims for reimbursement under the reasonable cost system are now pending on administrative and judicial review. As the large number of decisions by the courts of appeals addressing this issue shows, the question presented here regarding the scope of the PRRB's jurisdiction arises with some frequency in connection with those claims.

[13] Moreover, the conflict among the courts of appeals presents the Secretary with a difficult administrative problem. The Medicare statute permits a provider to seek judicial review in either the United States District Court for the District of Columbia or the federal district court for the district in which the provider is located (42 U.S.C. (& Supp. III) 1395*oo*(f)(1)). Although the law might be more favorable on the jurisdictional issue in the provider's home district, District of Columbia Circuit precedent on other issues might lead a provider to seek review in the latter district despite the unfavorable law regarding the jurisdictional issue. The Board thus cannot predict with certainty the forum that will be chosen by a particular provider. As a result, there is considerable potential for forum shopping leading to reversal of the Board's determinations and remands for reconsideration of the already-decided cases.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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AUGUST 1987

* The Solicitor General is disqualified in this case.

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In the Supreme Court of the United States

OCTOBER TERM, 1987

BETHESDA HOSPITAL ASSOCIATION AND
THE DEACONESS HOSPITAL OF CINCINNATI, OHIO,
PETITIONERS,

v.

OTIS R. BOWEN, M.D., SECRETARY OF
HEALTH AND HUMAN SERVICES,
RESPONDENT.

SUPPLEMENTAL BRIEF IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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SUPPLEMENTAL STATEMENT

At the time the petition for certiorari was filed on May 2, 1987, six courts of appeals had addressed the issue of self-disallowances. Since that date, one additional court of appeals has ruled on the issue, and one of the original six has issued a second decision on the issue. Both cases held in favor of the hospitals and against the Secretary, but used different analyses.

On May 18, 1987 the Ninth Circuit ruled that the Provider Reimbursement Review Board ("Board") has jurisdiction to hear self-disallowed costs. *Adams House Health Care v. Heckler*, 817 F.2d 587 (9th Cir. 1987). The court aligned itself with the Seventh Circuit decision in *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337 (7th Cir.), *cert. denied*, 464 U.S. 830 (1983), noting that the "plain language" of 42 U.S.C. § 1395oo(d) provides that the Board may review matters "not considered by the intermediary." 817 F.2d at 591. The court then analyzed the decision of the D.C. Circuit in *Athens Community Hospital, Inc. v. Heckler*, 743 F.2d 1 (D.C. Cir. 1984) ("Athens II"), *modifying Athens Community Hospital, Inc. v. Schweiker*, 686 F.2d 989 (D.C. Cir. 1982) ("Athens I"), rebutting in detail the five arguments raised in *Athens II* in support of the Secretary's interpretation, many of which were relied on by the Secretary in his Brief for the Respondent in the instant case. 817 F.2d at 591-594.

The Ninth Circuit also rejected the First Circuit's conclusion in *St. Luke's Hospital v. Secretary of Health and Human Services*, 810 F.2d 325 (1st Cir. 1987), that the Board has the discretion to hear or not hear appeals of self-disallowed issues. Instead, it found that the language in § 1395oo(d) (the Board "shall have the power" to affirm, reverse or modify an intermediary's determination) refers only to the Board's options once an appeal is filed, not to the Board's authority to refuse to hear an appeal. 817 F.2d at 594.

On May 5, 1987 the Eleventh Circuit also ruled in favor of the hospitals on the issue of self-disallowance, adopting an analysis not discussed by any of the other courts. In *Tallahassee Memorial Regional Medical Center v. Bowen*,[1] 815 F.2d 1435 (11th Cir. 1987), a case involving a direct challenge to the same Medicare reimbursement regulation challenged by the petitioners here, the court found that the relevant statutory provision governing Board jurisdiction is the third through sixth sentences of § 1395oo(f)(1).[2] 815 F.2d at 1459. These provisions allow hospitals to by-pass a hearing at the Board in instances where the Board cannot grant relief because it is bound by the very regulation the hospitals seek to challenge. Because subsection (f)(1) explicitly incorporates the jurisdictional requirements of subsection (a) but not subsection (d), and because the grant of judicial review in the by-pass provisions of subsection (f)(1) does not require a hearing at the Board, the court found the language in subsection (d) concerning the powers of the Board to be irrelevant. So long as a hospital meets the jurisdictional requirements of subsection (a), it is entitled to judicial review. 815 F.2d at 1461. Significantly, the court distinguished its earlier decision in *North Broward Hospital District v. Bowen*, 808 F.2d 1405 (11th Cir. 1987),[3] on the ground that the hospitals in *North Broward* were not challenging a Medicare regulation "but were merely attempting to raise with the PRRB claims that they inexplicably failed to raise with their intermediaries." 815 F.2d at 1457.

As a result of the *Adams House* and *Tallahassee* decisions, there is now a four-way rather than a three-way split among the circuits on the question whether the Board, and hence the court, has jurisdiction over self-disallowances. The Seventh and Ninth Circuits hold jurisdiction exists.

[1] A petition for a writ of certiorari was filed in the *Tallahassee* case on September 2, 1987, No. 87-380.

[2] Section 1395oo(f)(1) is reprinted at pages 4-5 of the Petition.

[3] A petition for a writ of certiorari was filed in the *North Broward* case on May 26, 1987, No. 86-1986.

The Fourth, Sixth and District of Columbia Circuits hold it does not exist. In the First Circuit, whether jurisdiction exists is up to the Board's discretion in each case. And now in the Eleventh Circuit, whether jurisdiction exists depends upon whether a hospital seeks to directly challenge a Medicare regulation. The petitioners respectfully submit that the issue is ripe for a definitive resolution by the Supreme Court.[4]

Respectfully submitted,

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[4] The listing required by Rule 28.1 was submitted in the petition for writ of certiorari filed on May 2, 1987.

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No. 86-1764

In the Supreme Court of the United States

OCTOBER TERM, 1987

BETHESDA HOSPITAL ASSOCIATION, ET AL.,
PETITIONERS,

v.

OTIS R. BOWEN, M.D., SECRETARY
OF HEALTH AND HUMAN SERVICES,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED MAY 2, 1987
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The following opinions, judgments, orders and other relevant documents have been omitted in printing this Joint Appendix because they appear on the following pages in the Appendix to the Petition For A Writ of Certiorari To The United States Court of Appeals For the Sixth Circuit filed in this matter:

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(No. C-1-83-0622)

04/21/83 – Complaint for Declaratory and Injunctive Relief and Sums Due Under the Medicare Statute (Docket No. 1)

11/04/83 – Amended Complaint for Declaratory and Injunctive Relief and Sums Due Under The Medicare Statute (Docket No. 18)

12/02/83 – Answer of Defendant Heckler (Docket No. 19)

05/11/84 – Motion to Dismiss Two of the Named Plaintiffs By Defendant (Docket No. 37)

05/31/84 – Opposition To Docket No. 37, By Plaintiffs Opposition to Defendant's Second Motion To Dismiss (Docket No. 43)

11/25/85 – Order of Remand Title 5 U.S.C. Sec. 706 does not provide for the granting of a judgment as prayed for by Plaintiffs. Action remanded to Secretary of HHS for further proceedings consistent with this Courts' opinion including the granting of judgment to plaintiffs in the amount of $2,965,767 plus post judgment interest at the statutory rate in accordance with the schedule attached to plaintiffs' motion and incorporated by reference herein (Docket No. 71)

02/20/86 – Order by Judge Spiegel that Defendant's motion to amend judgment (Doc. 72) is granted in part and that the next to last paragraph of the Court's Order dated 11/25/85 is amended, and that an additional paragraph is added to the order (Docket No. 78)

CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES IN THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT
(No. 86-3090)

01/24/86 – Notice of Appeal, filed (Docket No. 1)

08/08/86 – Brief of Appellant (Docket No. 16)

09/11/86 – Brief of Appellee (Docket No. 18)

10/02/86 – Reply Brief of Appellant (Docket No. 21)

10/02/86 – Letter from Clerk of Court advising counsel of date of oral argument (Docket No. 22)

02/02/87 – Opinion and Judgment (Docket No. 27)

02/17/87 – Petition For Rehearing En Banc by Appellees (Docket No. 31)

02/25/87 – Order Amending Opinion and Judgment of Feb. 2, 1987 (Docket No. 32)

07/01/87 – Order: Petition For Rehearing En Banc Denied (Docket No. 42)

07/16/87 – Opinion and Order With Mandate (Docket No. 43)

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO

Civil Action No.
C-1-83-0622

BETHESDA HOSPITAL, ET AL., PLAINTIFFS,

v.

MARGARET M. HECKLER,
SECRETARY OF HEALTH AND HUMAN SERVICES
ROOM 615-F HUMPHREY BUILDING
200 INDEPENDENCE AVENUE, S.W.
WASHINGTON, D.C. 20201, DEFENDANT.

(Filed November 4, 1983)

AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF AND SUMS DUE UNDER THE MEDICARE STATUTE

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(Filed November 4, 1983)

AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF AND SUMS DUE UNDER THE MEDICARE STATUTE

This is an action for declaratory and injunctive relief to determine questions of actual controversy between the parties, and requests a determination of the rights granted plaintiffs and the duties imposed upon defendant by Title XVIII of the Social Security Act, as amended, Health Insurance for the Aged and Disabled, commonly known as the Medicare program. Specifically, this action challenges the procedural and substantive validity of a regulatory amendment issued by the Secretary of Health, Education, and Welfare on June 1, 1979. The regulation effected a fundamental change in the Medicare method of reimbursement for malpractice insurance costs incurred by hospitals providing services to Medicare patients. The malpractice apportionment regulation, 42 C.F.R. § 405.452(b)(1)(ii), is a radical departure from long-

standing Medicare reimbursement principles and is inconsistent therewith; it was promulgated in violation of the Administrative Procedure Act, 5 U.S.C. § 553; and it is arbitrary, capricious, and in conflict with the Medicare statute. The result of the regulation is the reduction of reimbursement to plaintiff hospitals to less than the statutory standard of the "reasonable cost" of providing hospital services to Medicare patients; in addition, the regulation results in a prohibited shifting of costs of providing such services from the Medicare program to non-Medicare patients.

PARTIES

1. Plaintiffs (hereinafter "providers" or "hospitals") are licensed as acute general hospitals by the State of Ohio and are certified as "providers" of such services under Part A of the Medicare program. 42 U.S.C. § 1395x(u).

2. Defendant, Margaret M. Heckler (hereinafter "Secretary"), is the Secretary of Health and Human Services, and as such is responsible for the administration of the Department of Health and Human Services (HHS),* including the Medicare program. The Health Care Financing Administration (HCFA) is the operating component of HHS charged with administration of the Medicare program.

JURISDICTION AND VENUE

3. This action arises under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395xx (1974 and Supp.

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* The Department of Health and Human Services succeeded the Department of Health, Education, and Welfare (HEW) on May 4, 1980, pursuant to section 509(a) of the Department of Education Organization Act, Pub. L. 96-88, 93 Stat. 668. 42 F.R. 29642.

1982); the Administrative Procedure Act, 5 U.S.C. § 553; and the Declaratory Judgment Act, 28 U.S.C. § 2201.

4. Jurisdiction is grounded in 42 U.S.C. § 1395oo(f) and, with respect to Count I, in 28 U.S.C. § 1331.

5. Venue lies in this judicial district pursuant to 42 U.S.C. § 1395oo(f)(1).

THE MEDICARE PROGRAM

6. Title XVIII of the Social Security Act establishes a program of health insurance for the aged and disabled, commonly known as "Medicare." 42 U.S.C. §§ 1395-1395xx.

7. To participate in the Medicare program, a hospital must file a "provider agreement" with the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395cc, under which it agrees not to charge any Medicare patient for services covered by the Medicare program, in return for reimbursement by the program of the "reasonable cost" of such services. 42 U.S.C. § 1395f(b)(1)(A).

8. The regulations implementing the Medicare statute must ensure reimbursement of providers on the basis of the "reasonable cost" of such services. 42 U.S.C. §§ 1395x(v)(1)(A). "Reasonable cost" is defined as the "cost actually incurred, excluding therefrom any part of the incurred costs found to be unnecessary in the efficient delivery of needed health services. . . ." *Id.*

9. In promulgating regulations defining "reasonable cost," the Secretary is specifically directed by 42 U.S.C. § 1395x(v)(1)(A) to take into account both the direct and indirect costs of providers of services; to consider, among other things, the principles generally applied by national organizations or established prepayment organizations in making third-party payments for medical care; and to ensure that "the necessary costs of efficiently delivering

covered services to individuals covered by the [Medicare] program . . . will not be borne by individuals not so covered. . . ."

10. The Secretary has issued regulations to determine "reasonable cost" of services to Medicare beneficiaries. 42 C.F.R. Part 405, Subpart D, §§ 405.401-405.488.

FACTS RELATING TO PLAINTIFFS

11. During the cost years here at issue, each plaintiff had a provider agreement with the Secretary for the provision of Medicare services. The plaintiffs are appealing intermediary settlements for cost years ending in 1980 and 1981. (The cost years at issue and amounts in controversy are listed in the schedules attached to the Provider Reimbursement Review Board notices appended to this Complaint.)

12. The providers obtain malpractice insurance coverage through payment of premiums or contributions to self-insurance funds. The allowability of their malpractice insurance costs is not in dispute.

13. For the cost years here at issue, certain of the providers were legally obligated under the terms of borrowing indentures to obtain and maintain malpractice insurance coverage.

14. Prior to the challenged regulation, each plaintiff was reimbursed for its malpractice premium costs on the basis of Medicare utilization of services. The Medicare utilization rates for plaintiffs range from 19% to 50% for the cost years at issue.

15. All but two plaintiffs claimed reimbursement for malpractice insurance costs on that basis for the cost years at issue, despite the Medicare regulation and program instructions to the contrary. The providers' fiscal intermediary determined reimbursement for the providers' malpractice insurance costs on the basis of the challenged malpractice apportionment regulation, rather than those

claimed on the basis of utilization. The costs so claimed were disallowed by the intermediaries, and those cost years were accepted by the Board as properly before it.

16. Under the intermediary's Medicare reimbursement policies, however, inclusion of "nonallowable" costs in the cost report may be considered an act of fraud or program abuse. Similarly, if a provider claims as reimbursable an item which had been disallowed in a prior year, the provider may be subject to prosecution for Medicare fraud and abuse. Accordingly, following intermediary and Medicare program instructions, plaintiffs Bethesda Hospital and Deaconess Hospital for their cost years 1980 claimed only those malpractice insurance costs permitted by the new regulation, and filed an appeal with the Board after they received their Notices of Program Reimbursement. The Board refused to exercise jurisdiction over those cost years.

17. Those providers with no paid malpractice claims for the five-year period established by the regulation were reimbursed on the basis of a "national ratio" (5.1%) established by the regulation for the cost years at issue.

18. On March 24, 1982, plaintiffs requested a group hearing before the Provider Reimbursement Review Board pursuant to 42 U.S.C. § 1395oo(a) appealing the malpractice insurance costs disallowed in their Notices of Program Reimbursement.

19. On January 10, 1983, plaintiffs filed with the PRRB their brief and supporting materials. (The brief and supporting materials were reproduced in the Attachment to the original Complaint.)

20. The sole issue raised by plaintiffs' appeal of these cost years is the legality of the malpractice regulation.

21. Upon being informed that the PRRB would grant no hearings in any case which challenged the validity of the malpractice regulation, the group requested permission to

institute a civil action in federal district court pursuant to 42 U.S.C. § 1395oo(f)(1).

22. On February 18, 1983, the PRRB issued a notice that it lacks the authority to determine the validity of the malpractice regulation, and granted the group permission to proceed to federal court on an expedited basis. (Appendix A to original Complaint.) With respect to cost years for Bethesda Hospital and Deaconess Hospital, the PRRB concluded that it had no jurisdiction over their appeals because the providers did not claim reimbursement for their malpractice insurance costs based on Medicare utilization, despite the fact that they had simply followed the Secretary's regulations and instructions in filing their cost reports. (Appendix B to original Complaint.)

THE CHALLENGED REGULATION

23. Medicare regulations require providers to account for their expenses in various "cost centers." 42 C.F.R. § 405.453.

24. From its inception, the Medicare program has reimbursed both the direct and the indirect costs of each cost center on the basis of Medicare patients' actual use of the services of that center (the Medicare utilization rate). 42 C.F.R. §§ 405.402(b)(3) and 405.452(b)(1).

25. From its inception, the Medicare program has required each provider to accumulate all of its overhead or "administrative and general" ("A and G") costs in "A and G" cost centers. These A and G cost centers included costs such as those of admission offices, billing departments, legal and accounting services, and pastoral care as well as all insurance costs, including fire, casualty, accident, malpractice insurance premiums or contributions to self-insurance funds.

26. By allocating the A and G costs to revenue-producing cost centers which are reimbursed on the basis of the percentage of Medicare utilization, the Medicare

program has consistently reimbursed these costs in the same manner as all other costs, *i.e.*, in proportion to the utilization by Medicare patients of the provider's services.

27. The regulation for the reimbursement of malpractice costs (the "malpractice regulation"), challenged herein, was promulgated on June 1, 1979, effective for cost reporting periods beginning after June 30, 1979. It establishes a "unique exception" to the traditional utilization approach to the allocation of costs between Medicare and non-Medicare patients. 44 Fed. Reg. 31641-31642.

28. The regulation removes malpractice insurance costs from the A and G pool of costs subject to traditional cost finding and apportionment based on actual Medicare utilization of services. It requires, instead, that they be "directly" apportioned between Medicare and non-Medicare patients "based on the dollar ratio of the provider's Medicare paid malpractice losses to its total paid malpractice losses for the current cost reporting period and the preceding four-year period." 44 Fed. Reg. 31642.

29. A provider with no malpractice losses whatsoever for the five-year period is reimbursed in accordance with the "national ratio of malpractice awards paid to Medicare beneficiaries to malpractice awards paid to all patients." *Id.* The preamble to the regulation establishes the "national ratio" at 5.1%. *Id.*

30. The malpractice regulation effects a radical departure from the principle that overhead costs be apportioned among payors based on their use of the actual services provided.

31. Under the malpractice regulation, a hospital such as Miami Valley Hospital, with no malpractice paid claims of *any* kind for the relevant five-year period, is reimbursed only 5.1% of its malpractice premium costs, despite the fact that Medicare patients used approximately 33% of its services during its cost year ending 1980. The resulting

decrease in Medicare reimbursement for this hospital for one cost year alone is more than $408,800.

32. A provider with only one paid claim, a non-Medicare patient claim, is reimbursed by Medicare under the new regulation for *none* of its malpractice premium costs, despite the fact that hospitals such as plaintiffs provide from 19% to 50% of their services to Medicare patients. The corresponding percentage of malpractice premiums in such hospitals is directly and exclusively attributable to Medicare patient-days.

33. A provider with only one paid claim during the five-year period is paid 100% of its malpractice premium costs if the paid claim relates to a Medicare patient.

34. The result of this regulatory scheme is that a few providers are overreimbursed, and many providers are significantly underreimbursed for their malpractice premium costs. The adverse effect is intensified because of the inability of an individual provider to determine or predict its loss experience and resulting reimbursement levels.

35. Malpractice insurance rates for plaintiffs are set on a patient-day or patient-visit basis, without regard to whether a patient is a Medicare patient.

36. Other third-party cost-reimbursement payors do not reimburse malpractice premium costs on a "paid claims" basis; rather, they reimburse approximately that percentage of malpractice costs which represents their insureds' utilization of hospital patient days.

37. The malpractice regulation results in reimbursement which bears no relationship to premium "costs actually incurred" with respect to Medicare beneficiaries; it creates significant inequities among providers; and it seriously undermines the financial stability of providers, whose Medicare reimbursement rate can fluctuate wildly depending on paid claims.

DEVELOPMENT OF THE MALPRACTICE REGULATION

38. The Medicare statute was enacted as part of the Social Security Amendments of 1965, P.L. 89-97. After protracted negotiations with provider representatives, consultation with other third-party payors, and extensive review by both the Health Insurance Benefits Advisory Council and the Senate Finance Committee, the Secretary issued the Medicare reimbursement regulations on November 23, 1966. 31 Fed. Reg. 14808. Since the inception of the program, the principles of cost-finding and cost apportionment have remained fundamentally unchanged.

39. A Notice of Proposed Rulemaking was published on March 15, 1979. 44 Fed. Reg. 15744. The NPRM purported to justify the proposed revision on the ground that the traditional utilization approach "results in Medicare paying for a disproportionate amount of malpractice costs." 44 Fed. Reg. at 15745.

40. The sole support for this conclusion of the Secretary in the NPRM was a reference to an unidentified "study conducted by an HEW consultant [which] indicates that malpractice awards for Medicare . . . patients are significantly lower in amount than losses for other patient population [*sic*]." 44 Fed. Reg. 15745.

41. Nowhere in the NPRM did the Secretary identify the study which formed the basis for his proposal.

42. The NPRM did not describe the study's methodology, offer to make the study available to commentors, or provide any information to enable commentors to assess the reliability of the study's findings.

43. Contrary to the mandate of Executive Order 12044 that agencies allow the public at least a 60-day comment period for proposed regulations, 43 Fed. Reg. 12661 (March 23, 1978), the notice allowed only 45 days, "[b]ecause of [HEW's] interest in making these regulations effective for cost reporting periods beginning on or after July 1, 1979." 44 Fed. Reg. at 15745. The NPRM stated

that "[i]n our view, this proposal is not complex and 45 days should provide an adequate opportunity for interested parties to analyze it and submit comments." *Id.*

44. HEW ultimately abandond its attempt to circumvent the requirements of E.O. 12044 by publishing on May 1, 1979, a notice reopening the comment period for an additional 15 days. 44 Fed. Reg. 25476.

45. The Deputy General Counsel for Regulation Review reported to the Office of the Secretary before publication of the final rule that the regulation's preamble was neither adequate nor clearly written; further, HCFA received some 450 public comments on the NPRM. All of the public comments opposed the proposed regulations. Therefore we believe that HCFA needs to carefully explain why it is rejecting the public comments.

46. Approximately 600 comments on the proposed rule were submitted by health care institutions, consumers, major accounting firms, insurance companies, risk managers, nurses, health care consultants, actuaries, physicians, and Medicare beneficiaries.

47. The 600 comments included those which pointed out the defects in the statistical validity of the Westat report; challenged the Secretary's assumption that an individual provider's paid claims history determines the amount of malpractice insurance premium cost actually incurred; questioned whether the rule accurately apportions malpractice expenses; explained that the administrative burdens of obtaining the information needed to implement the rule were significant, and in some cases insurmountable; objected to the unfairness of requiring discrete-costing of malpractice insurance premiums while the Secretary consistently refused to permit discrete-costing of administrative costs which are solely or primarily Medicare-related; and challenged the legality of the proposed rule under the Medicare statute.

48. On June 1, 1979, HEW published the regulation in final form. 44 Fed. Reg. 31641-42. The Secretary acknowledged that "[a]ll comments received were against the proposal and recommended that [HEW] withdraw it entirely." *Id.* at 31642.

49. The preamble, which had been determined by the Secretary's own counsel to be inadequate, nonresponsive, and poorly written was published *verbatim*.

50. The rulemaking record contains no evidence that the Secretary seriously considered the great majority of the issues raised by the comments in promulgating the final rule.

51. The Secretary's staff identified at least 19 major categories of issues raised by the comments.

52. The comments which highlighted the serious defects in the sole basis for the regulation (the Westat study) were not even evaluated during the rulemaking process.

53. Although the author of the regulation proposal was asked to respond on May 8, 1979, to major comments questioning the validity of the Westat study, he failed to do so until July 5, 1979, more than a month after the final regulation was issued.

54. The preamble addresses only four of the numerous criticisms raised by the comments, and those responses are conclusory and inadequate. The preamble fails to acknowledge or discuss the remainder.

55. Internal agency documents demonstrate that the stated rationale for the regulation is untrue.

56. The 5.1% "national ratio" which appeared in the final regulation was not discussed in the proposed rule.

57. The rulemaking record contains no evidence that the Secretary conducted any study or survey of the principles generally applied by other third-party payors in reimbursing the costs of malpractice insurance.

THE WESTAT STUDY

58. The study referred to in the NPRM is that performed by Westat, Inc., under PHS Contract 282-76-TQ-0497 and published as *Medical Malpractice Closed Claim Study—1976.*

59. The data collected and analyzed in the study were recorded on magnetic tapes pursuant to section I.C. 10 of PHS Contract 282-76-TQ-0497.

60. The Westat study report is the sole basis cited in the NPRM or final regulation for the conclusion that the Medicare program had overreimbursed hospitals for malpractice insurance costs under the traditional methodology.

61. The Westat study report is the sole basis cited for the final regulation's conclusion that the Medicare program had overreimbursed hospitals for malpractice insurance costs under the traditional methodology.

62. The Westat study report is the sole basis cited in the final regulation or NPRM for the 5.1% "national ratio."

63. The Westat study is not a suitable factual basis for any generalizations about hospital malpractice claims by Medicare patients.

64. Rather than support a radical revision of reimbursement methodology, the Westat data, analyzed properly, demonstrate that the traditional methodology is appropriate and accurately reimburses Medicare providers.

65. The Westat study "sample" was heavily biased by the inclusion of claims against physicians.

66. Claims against hospitals represented only 20% of the claims dollars in the data base.

67. Physician defendants accounted for only 4.4% of total dollars paid on behalf of Medicare patients and 9.2% of total claims by Medicare patients.

68. Hospitals accounted for 17.8% of dollars paid on behalf of Medicare patients and 19.9% of claims by Medicare patients in the Westat data base.

69. HEW itself estimated malpractice premiums reimbursed by medicare during the relevant time period to be only 20% in its synopsis of the Westat Study titled *Medical Malpractice Claims: A Synopsis of the HEW/Industry Study of Medical Malpractice Insurance Claims.*

70. In evaluating the data of the Westat study for purposes of the regulation proposal, the Secretary mismatched statistics: the Westat data related to incidents in medical care provided primarily in 1973 and, therefore, does not correlate with Medicare expenditure data from much later time periods.

IMPACT ON PROVIDERS

71. Because Medicare reimbursement represents a large part of the revenues of hospitals with significant Medicare utilization, their financial viability is very sensitive to Medicare reimbursement fluctuations.

72. Insurers do *not* set hospital insurance rates based on patient age or source of payment (Medicare status); neither do third-party payors reimburse insurance costs on those bases.

73. As a result, non-Medicare patient charges will have to be increased to make up the deficit, a classic example of cost-shifting explicitly prohibited by the Medicare statute.

EFFECT OF THE REGULATION

75. The malpractice regulation singles out malpractice insurance costs from all other hospital costs for special treatment, with no rational basis for so doing.

76. The malpractice regulation leads to incongruous and unfair reimbursement consequences.

77. Under the malpractice regulation, providers such as plaintiffs are grossly under-reimbursed for those portions of their medical malpractice premiums and self-insurance fund contributions incurred in the care of Medicare patients.

78. Non-profit providers, such as plaintiffs, must increase charges to non-Medicare patients to cover the unreimbursed costs of care to Medicare patients.

79. The malpractice regulation results in reimbursable amounts which bear no relationship to premium costs actually incurred with respect to Medicare beneficiaries.

COUNT I

80. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

81. The challenged malpractice regulation is procedurally defective, in that it was promulgated without compliance with the notice and comment requirements of the Administrative Procedure Act, 5 U.S.C. § 553, for the following reasons:

a. The notice of proposed rulemaking failed to provide sufficient information for meaningful comment;

b. The final rule included a material provision (the 5.1% "national ratio") neither presented nor suggested by the notice of proposed rulemaking;

c. The basis and purpose statement of the malpractice regulation demonstrated the Secretary's failure to consider major relevant factors raised by public comments and the internal HHS review process;

d. The Secretary failed adequately to respond to public comments;

e. The Secretary was irrevocably committed to promulgating the malpractice regulations and the resulting

rulemaking proceeding totally deprived providers, including plaintiffs, of due process.

COUNT II

82. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

83. The defendant's promulgation of the malpractice regulation was arbitrary, capricious, and an abuse of discretion within the meaning of the Administrative Procedure Act § 706(2)(A), 5 U.S.C. § 553, because:

a. its stated purpose was to remedy an *assumed* existing malapportionment of malpractice insurance costs, but no such malapportionment exists or was shown to exist—the sole basis cited for the regulation, the Westat study, does not measure hospital loss experience for Medicare patients and provides no factual support for the assumption underlying the regulation;

b. the "national ratio" was grossly miscalculated—when only *hospital* claims experience is analyzed in the Westat data base, the "national ratio" increases to approximately 17%, as opposed to the 5.1% adopted by the Secretary;

c. the application of direct apportionment only to costs favorable to the Secretary is inequitable and destroys the integrity of the Medicare cost-finding system;

d. the rule has incongruous reimbursement effects which threaten the financial stability of providers because reimbursement is not rationally related to the malpractice premium costs incurred;

e. the regulation is contrary to sound public policy because it encourages manipulation of malpractice claims settlements.

COUNT III

84. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

85. The malpractice regulation violates the Medicare statute, specifically 42 U.S.C. § 1395x(v)(1)(A), because it fails to reimburse "reasonable cost" in the following respects:

a. The "paid claims" basis of the regulation fails to reimburse those providers, including plaintiffs, for the reasonable malpractice premium costs "actually incurred" with respect to Medicare beneficiaries, as those premium costs are determined through the processes actually used by insurers, including plaintiffs' insurers;

b. The use of the purported "national average" in lieu of actual "paid claims" experience fails to reimburse individual providers for the premium costs "actually incurred";

c. The regulation shifts costs of care provided to Medicare patients from the Medicare program to non-Medicare patients;

d. The regulation was promulgated without consideration of the principles generally applied by national organizations or other third-party payors;

e. By directly apportioning malpractice costs for reimbursement while requiring that all other A & G costs remain in the indirect cost pool to be apportioned on the basis of utilization, the regulation destroys the integrity of the averaging process which is central to the cost finding and apportionment system, and results in the underreimbursement of the remaining indirect costs.

COUNT IV

86. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

87. To the extent that the direct apportionment concept embodied in the challenged regulation is not *per se* violative of the reimbursement provisions of the Medicare statute, it is violative of the Medicare statute as applied. The regulation purports to apply the direct apportionment methodology to all malpractice insurance costs, even to those costs which are fixed. Direct apportionment based on paid loss experience may be applied only to that portion of malpractice insurance costs which are, like the regulation methodology, based on paid loss experience.

COUNT V

88. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

89. The decision of the Provider Reimbursement Review Board that it was without jurisdiction with respect to Bethesda Hospital and Deaconess Hospital because the providers had claimed malpractice costs under the methodology dictated by the new regulation and instructions is contrary to the law in the following respects:

(a) 42 U.S.C. § 1395oo(a) affords a provider the right to a "hearing with respect to [its] cost report" if it is "dissatisfied with a final determination" of its fiscal intermediary with respect to the "amount of total program reimbursement due to the provider for the items and services furnished" to Medicare beneficiaries;

(b) Nothing in the language of 42 U.S.C. § 1395oo(a) prohibits the Board from taking jurisdiction over a claim by a provider who followed mandated cost reporting procedures but who raised those issues with the Board and has not been fully reimbursed for services rendered to Medicare beneficiaries;

(c) 42 U.S.C. § 1395oo(d) confers upon the PRRB jurisdiction over reimbursement "matters" covered by the

entire cost report "even though such matters were not considered by the intermediary in making such a final determination;"

(d) The Board's denial of jurisdiction violates the intent of Congress.

COUNT VI

90. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

91. The Board's final decision denying jurisdiction with respect to Bethesda Hospital and Deaconess Hospital is contrary to defendant's own regulations in the following respects:

(a) Neither 42 C.F.R. § 405.1835 nor § 405.1839 establishes "intermediary adjustments" as a predicate to the Board's jurisdiction to review Medicare reimbursement matters.

(b) Nothing in the defendant's regulations requires that intermediary adjustments be made only in the Notice of Program Reimbursement.

92. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

93. The Board's final decision in this case operates to deny plaintiffs due process of law under the Fifth Amendment to the Constitution of the United States, for the following reasons:

(a) Review by the Board is the sole avenue provided by the Medicare statute for adjudication of provider's reimbursement claims;

(b) Absent a clear indication that Congress intended to limit its jurisdiction, the Board should not limit its range of inquiry to deny providers the right to be heard with respect to unreimbursed costs arising from services rendered to Medicare beneficiaries.

WHEREFORE, the plaintiffs pray:

a. for a declaration by this court that the malpractice regulation is arbitrary, capricious, and an abuse of the Secretary's discretion, and is therefore substantively invalid under 5 U.S.C. § 706(2)(A);

b. for a declaration by this court that the malpractice reguiation is inconsistent with the Medicare statute, specifically 42 U.S.C. § 1395x(v)(1)(A);

c. for a declaration by this court that the malpractice regulation was promulgated in violation of the notice and comment procedures of 5 U.S.C. § 553;

d. for an order enjoining the defendant and her officers, agents, and employees from applying, enforcing, relying on, or otherwise effectuating the provisions of the rule unless and until the Secretary complies fully with the procedure requirements imposed by law;

e. for a declaration by this court that (1) the defendant illegally applied the malpractice regulation in determining the plaintiffs' reimbursement for the cost years at issue and that (2) plaintiffs are entitled to be reimbursed for its malpractice costs in accordance with the cost apportionment rules in effect for all other administrative and general costs, or in the alternative, that direct apportionment applies only to that part of the premium that actually varies based on individual hospital loss experience; or, in the alternative, for a declaration that the statute requires that providers be permitted to directly apportion costs demonstrably under-reimbursed by Medicare;

f. for a declaration by this court that the Provider Reimbursement Review Board had jurisdiction over the cost year ending 1980 for Bethesda Hospital and Deaconess Hospital, and that those providers' 1980 cost years are properly before this court;

g. for an order of this court awarding plaintiffs the sums due, together with interest thereon as provided by law;

h. for costs of suit incurred by plaintiffs; and

i. for such other relief as this court may deem appropriate.

Respectfully submitted,

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISIONS

Civil No. C-1-83-0622

BETHESDA HOSPITAL, ET AL., PLAINTIFFS,

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

(Filed Dec. 2, 1983)
Judge S. Arthur Spiegel

ANSWER

Defendant by and through her undersigned counsel, answers the plaintiffs' complaint as follows:

First Defense

The complaint fails to state a claim upon which relief may be granted.

Second Defense

Plaintiffs Bethesda Hospital and Deaconess Hospital failed to raise their claim for reimbursement in their cost reports and thus are not properly before this Court. This Court is without jurisdiction to hear their appeals.

Third Defense

The defendant answers each of the numbered paragraphs in the plaintiffs' complaint as follows:

1. Admitted.
2. Admitted.

3. Defendant admits that this case arises under the Medicare Act. The defendant denies that the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.* or the Declaratory Judgment Act, 28 U.S.C. § 2201 afford this Court any basis for jurisdiction to review the actions of the Secretary of Health and Human Services in the circumstances described in this case.

4. Defendant admits that the sole jurisdiction of the Court to review the actions of the Secretary is that jurisdiction which is conferred by the Medicare Act itself, specifically 42 U.S.C. § 1395oo(f), as amended by section 955 of the Omnibus Reconciliation Act of 1980. The defendant denies that this Court has jurisdiction under 28 U.S.C. § 1331.

5. Admitted.

6. Admitted, except to deny that the Medicare program is an insurance program in any way governed by general principles of insurance law.

7. Paragraph 7 contains plaintiffs broad characterization of the "provider agreements" entered into between the Secretary and hospitals seeking to participate in the Medicare program and to which no answer is required. The Court is respectfully referred to the full text of these agreements and to the provisions of the Medicare Act upon which they are based for the complete meaning thereof. The defendant affirmatively states that these agreements are voluntarily entered into by the many providers seeking the advantages of the Medicare program.

8-9. Paragraphs 8 and 9 contain plaintiffs' characterization of one section of the Medicare Act dealing with the determination of "reasonable costs" and not averments of fact to which an answer may be required. The Court is respectfully referred to the full text of that section and to other sections of the Act for a complete statement of their contents.

10. The defendant admits that she has been charged with the authority and responsibility by Congress to implement the Medicare Act through regulation. The Court is respectfully referred to the full text of those regulations and to the interpretive manuals and other guidelines which the Secretary has issued for the complete contents thereof.

11. Admitted.

12. The defendant is without knowledge or information sufficient to form a belief as to the first sentence of this paragraph. The defendant admits the second sentence with the qualification that such malpractice insurance costs are considered allowable Medicare expenses solely within the meaning of 42 CFR 405.452(b)(1)(ii).

13. The defendant is without knowledge or information sufficient to form a belief as to the allegations contained in this paragraph. To the extent that an answer may be required, the defendant denies that a hospital's obligations under a bond indenture or other indebtedness is relevant to the validity of the Secretary's malpractice regulation.

14-15. The defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations contained in these paragraphs.

16. The defendant is without knowledge or information sufficient to form a belief as to why or on what theory plaintiffs Bethesda Hospital and Deaconess Hospital failed to "step down" the costs of their malpractice insurance in such way as to perfect their claim for appeal to the Provider Reimbursement Review Board. The defendant affirmatively avers that absent a disallowance on the cost report, these two plaintiffs failed to raise their claim to the PRRB and are not now properly before this Court.

17-18. Admitted.

19. The defendant admits that the documents mentioned in this paragraph were filed before the Provider Reimbursement Review Board but denies that the documents originally identified in Volume II, Attachment C are relevant and admissible with respect to the issues that are raised in this litigation.

20. The defendant admits that the sole issue before this Court is the validity of the Secretary's malpractice insurance cost regulation and affirmatively states that the standard this Court must use in reviewing that regulation is whether, based upon the information that was before the Secretary at the time the regulation was promulgated, the regulation is reasonable and consistent with the Medicare statute.

21. The defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations contained in this paragraph.

22. Admitted, except to deny that plaintiffs Bethesda Hospital and Deaconess Hospital are properly before this Court.

23-24. Paragraphs 23 and 24 contain plaintiffs' conclusions of law and not averments of fact to which an answer may be required. The Court is respectfully referred to the full text of the cited regulations for a complete statement of their contents.

25. Paragraph 25 contains plaintiffs' characterization of the application of the Secretary's regulation concerning general and administrative costs and to which an answer is not required. The Court is respectfully referred to the full text of this regulation for a complete statement of its contents. The defendant denies that the examples cited by the plaintiffs in this paragraph are the only examples of such general and administrative costs.

26. The defendant admits that as a general rule a utilization-based formula has been the basis for the determination of most Medicare reimbursement in stepping down the costs of revenue producing cost centers under Medicare. The defendant denies any implication that the utilization method was the only method available to the Secretary or the only method permitted by law.

27. The defendant admits the first sentence of this paragraph. With respect to the second sentence, the defendant admits only that the words cited by the plaintiffs appear in the preamble to that regulation and the Court is respectfully referred to the full text of that Notice of Proposed Rulemaking for a complete statement of its contents.

28. Paragraph 28 contains plaintiffs' characterization of the Secretary's malpractice insurance cost regulation and not an averment of fact to which an answer may be required. The Court is respectfully referred to the full text of the cited regulation for a complete statement of its contents.

29. The defendant admits only that in the example given, a hospital voluntarily participating in the Medicare program, having experienced no malpractice loss during the five year period required under the malpractice regulation, will receive 5.1% of its malpractice insurance costs as Medicare reimbursement.

30. Denied.

31. The defendant is without knowledge or information sufficient to form a belief as to the actual malpractice loss experience or Medicare utilization of the plaintiff hospitals.

32. The defendant admits that a hospital having experienced only *non-Medicare* related malpractice losses, will receive no reimbursement for the costs of its malpractice insurance since the hospital has experienced no cost which is related to Medicare as that expression is used in the Medicare Act.

33. For the inverse of the same reason as expressed in the defendant's answer to paragraph 37, the defendant admits that a hospital having experienced only *Medicare-related* malpractice losses will receive 100% of its malpractice insurance costs as Medicare reimbursement.

34. Denied.

35. The defendant denies the relevancy of this allegation.

36. The defendant denies the relevancy of the allegation contained in this paragraph even if taken as true.

37. Denied.

38. Paragraph 38 contains plaintiffs characterization of certain aspects of the Medicare program and conclusions of law thereon to which no answer is required. The Court is respectfully referred to the full text of the Act for a complete statement of its contents. The last sentence of this paragraph is denied.

39. Admitted, except to deny any connotation attributed to the word "purported" as used in this paragraph.

40. Denied, except to admit that the regulation was based on the Secretary's stated conclusion that Medicare patients were the cause of a significantly lower ratio of malpractice losses.

41-42. Denied, except to admit that the study was widely known and identified to the general public and was specifically addressed by several commentors, including major hospital trade associations.

43. Denied, except to admit that the NPRM called for a 45-day comment period.

44. Denied, except to admit that on May 1, 1979 the Secretary approved a 15-day extension of the comment period, to May 15, 1979.

45. Denied, except to admit that the named official did indicate an opinion that a more detailed preamble would be preferred.

46. The defendant admits that hundreds of comments were received during the comment period and positively avers that this demonstrates the adequacy of the public notice and comment period and the awareness in the gen-

eral community and in the hospital industry as to the contents of the Secretary's regulation, its basis and purpose.

47. Denied, except to admit that the Secretary received comments containing various criticisms of the proposed regulations, including challenges to the Westat Report and to the Secretary's conclusions resulting at least partially from that report. The Court is respectfully referred to the full text of the various comments received by the Secretary in response to the NPRM for the full and complete contents thereof. The defendant affirmatively avers that the comments do indicate the public awareness of and response to the Westat Report.

48. Admitted.

49. Denied, except to admit that the final preamble was the same as circulated among Department officials for comment.

50. Denied, except to admit that on June 1, 1979, the final regulation was published including an extensive preamble which outlined the Secretary's purposes in promulgating the regulation and which discussed the public reaction to the proposal.

51. Denied, except to admit that officials of the Department closely reviewed the many comments received during the comment period, thus demonstrating the depth of consideration given to this regulation by the Secretary and her staff.

52. Denied.

53. Denied, except to admit that a response to a request for comment was received on July 5, 1979.

54. Denied.

55. Denied.

56. Denied.

57. Denied, except to admit that the Secretary is not bound by third party insurance practices and accounting procedures.

58. Admitted.

59. Admitted.

60. Denied.

61. Denied.

62. Denied, except to admit that the 5.1% was derived from the nearly universal statistical sample accumulated as part of the Westat Report.

63. Denied.

64. Denied.

65. Denied.

66-68. Denied, except to admit that the figures stated by the plaintiffs are estimated from statistics contained in the Westat study.

69. Denied.

70. Denied.

71. Paragraph 71 represents plaintiffs' characterization of the impact of Medicare reimbursement on an individual hospital's "financial viability." The defendant is without knowledge or information sufficient to form an opinion as to any individual hospital and would admit only that Medicare currently accounts for up to 40 percent of the revenues of the average hospital and that many individual hospitals may be higher or lower than that average.

72. Denied and the defendant affirmatively states that the Medicare program is not bound by the premium-setting practices of malpractice insurance companies nor is it required to follow the third-party payment practices of the private health insurance industry. Plaintiffs' inference drawn from these erroneous assumptions are totally incorrect.

73. Denied.

74. [Plaintiffs' Complaint Has No Paragraph #74].

75. Denied.

76. Denied.

77. Denied.

78. Denied.

79. Denied.

80. The defendant reiterates and incorporates by reference herein, the answers she has already given to paragraphs 1 through 79 of the Complaint.

81. Denied.

82. The defendant reiterates and incorporates by reference herein, the answers she has already given to paragraphs 1 through 81 of the Complaint.

83. Denied.

84. The defendant reiterates and incorporates by reference herein, the answers she has already given to paragraphs 1 through 83 of the Complaint.

85. Denied.

86. The defendant reiterates and incorporates by reference herein, the answers she has already given to paragraphs 1 through 85 of the Complaint.

87. Denied.

The defendant hereby specifically denies all allegations, inferences and conclusions contained in the Complaint which have not here before been otherwise answered.

Fourth Defense

The Court lacks jurisdiction over the subject matter of this action to the extent that the plaintiff seeks any determination, finding or order of this Court other than as to the legal sufficiency and validity of the Secretary's regulation concerning Medicare reimbursement for the costs of malpractice insurance.

WHEREFORE the defendant asks that judgment be entered dismissing the complaint and affirming the validity of the challenged regulation and such other and further relief as the Court may deem appropriate.

Respectfully submitted,

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CERTIFICATE OF SERVICE OMITTED IN PRINTING.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION
Title omitted in printing.

Plaintiffs' Opposition To
Defendant's Second Motion To Dismiss
Attachment B-1

Excerpts from FYE 1980 Cost Report
BETHESDA HOSPITAL

Form Approved
OMB No. 68-R0078

WORKSHEET CHECKLIST FOR HOSPITAL, HOSPITAL-SKILLED NURSING FACILITY COMPLEX AND SKILLED NURSING FACILITY COST REPORT

PROVIDER NO: 36-0193 PERIOD: FROM January 1, 1980 TO December 31, 1980

	CHECK THE APPROPRIATE COLUMN FOR EACH WORKSHEET	Completed		
		HCFA Worksheet	Submitted Worksheet	Not Applicable
	WORKSHEETS	1	2	3
1	Worksheet Checklist			
2	Hospital and Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Statistical Data – Part I	X		
3	Hospital and Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Statistical Data – Parts II and III			
4	Hospital and Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Statistical Data – Parts IV and V			X
5	Worksheet A		X	
6	Worksheet A-1		X	
7	Worksheet A-2			X
8	Worksheet A-3			X
9	Worksheet A-4			X
10	Worksheet A-5			X
11	Worksheet A-6		X	
12	Worksheet A-7	X		
13	Worksheet A-8		X	
14	Worksheet A-8-1	X		
15	Worksheet A-8-2	X		
16	Worksheet B		X	
17	Worksheet B-1		X	
18	Worksheet C		X	
19	Worksheet D		X	
20	Worksheet D-1 – Part I (All Pages Must Be Completed)		X	
21	Worksheet D-1 – Part II		X	
22	Worksheet D-2			X
23	Worksheet D-3		X	
24	Worksheet D-6		X	
25	Worksheet E – Part I – Modified	X		
26	Worksheet E – Part II – Modified	X		
27	Worksheet E – Part III – Modified	X		
28	Worksheet E-1	X		
29	Worksheet E-2 – Modified	X		
30	Worksheet E-5 – Parts I and II			X
31	Worksheet E-5 – Part III			X
32	Worksheet G	X		
33	Worksheet G-1	X		
34	Worksheet G-2	X		
35	Worksheet G-3	X		

SUPPLEMENTAL WORKSHEETS (AVAILABLE UPON REQUEST FROM INTEMEDIARY):

36	HCFA-2552A – Supplemental Worksheet D-4			
37	HCFA-2552A – Supplemental Worksheet D-5			
38	HCFA-2552B – Supplemental Worksheet D-8			
39	HCFA-2552C – Supplemental Worksheet D-7			
40	HCFA-2552D – Supplemental Worksheet E-3			
41	HCFA-2552E – Supplemental Worksheet E-4			
42	HCFA-2552F – Supplemental Worksheet E-4-1			
43	HCFA-2552G – Supplemental Worksheet F – Part I			
44	HCFA-2552G – Supplemental Worksheet F – Part II			
45	HCFA-2552G – Supplemental Worksheet F – Part III			
46	HCFA-2552H – Supplemental Worksheet A-8-3			

Supplemental Worksheets H, I, J, K, L, M, N, P, Q, X

If substitute worksheets are a part or all of this cost report (a check in column 2), enter the name and address of the person, company forms preparation service which originated the substitute worksheet(s):

NAME : Ernst & Whinney

ADDRESS: 2400 Nationwide Plaza

Columbus, Ohio 43215

Form HCFA-2552 (5-80)
Destroy old stock

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This report is required by law (42 USC 1395g, 20 CFR 405.406(b)). Failure to report can result in all reasonable payments under Title XVIII during the cost report period being deemed overpayments (42 USC 1320a-3).

Form Approved
OMB No. 68-R0178

HOSPITAL, HOSPITAL-SKILLED NURSING FACILITY COMPLEX AND SKILLED NURSING FACILITY STATISTICAL DATA

INTERMEDIARY USE ONLY
☐ AUDITED ☐ DESK REVIEWED

DATE RECEIVED

INTERMEDIARY NO.

PART I – GENERAL

1. Names and Addresses	Provider Number/s	Dates Certified
HOSPITAL: BETHESDA HOSPITAL	36-0193	7/66
SUBPROVIDER I:		
SUBPROVIDER II:		
SKILLED NURSING FACILITY:		
HOME HEALTH AGENCY:		
SPECIAL PROVIDER-CONTROLLED FACILITY:		

2. Cost Reporting Period From January 1, 1980 To December 31, 1980

3. Type of Control

a. Voluntary Hospital:
☐ Church
☒ Other (Specify)

b. Proprietary:
☐ Individual ☐ Partnership
☐ Corporation ☐ Other (Specify)

c. Government:
☐ Federal ☐ State ☐ Other (Specify)
☐ City-County ☐ Hospital District
☐ County ☐ City

4. Type of Hospital

a.
☒ General-Short Term ☐ Specialty Long-Term
☐ General-Long Term ☐ Chronic Disease
☐ Tuberculosis ☐ Psychiatric
☐ Specialty Short-Term ☐ Other (Specify)

b. Medicare Certified Kidney Transplant Hospital: ☐ Yes ☐ No

5. Type of Skilled Nursing Facility

☐ Entirely Certified Skilled Nursing Facility
☐ Partially Certified Skilled Nursing Facility
☐ Skilled Nursing Facility Unit of Domiciliary Institution
☐ Skilled Nursing Facility Unit of Rehabilitation Center
☐ Other (Specify)

6. Health Care Programs
☐ Title V ☐ Title XVIII ☐ Title XIX

7.

a. Are management and/or administrative support services purchased from an outside supplier or organization? ☐ Yes ☐ No

b. If yes, what is the total amount for these services as reported in Worksheet A, column 7? $

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Statement of Reimbursable Cost and the Balance Sheet and Statement of Revenue and Expenses prepared by THE BETHESDA HOSPITAL ASSOCIATION (PROVIDER NO. 36-0193) (Provider name(s) and number(s)) for the cost report period beginning January 1, 1980 and ending December 31, 1980, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted. (See specific notes included)

We reserve the right to refile this cost report if the manner in which we included the reimbursement for certain controversies is not acceptable for protecting our appeal rights.

(Signed) Joe Reese
Officer or Administrator of Provider(s)
Joe Reese
Title Controller
Date

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37a

SAMST & WHIMMLY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/90
HOSPITAL AND HOSPITAL-SKILLED NURSING FACILITY COMPLEX
STATISTICAL DATA
SUBMITTED IN LIEU OF HCFA-2552, PAGE 3

RUN DATE: 04/29/91

PART II - HOSPITAL STATISTICS

		SPECIAL CARE UNITS			
	GENERAL SERVICE	ICU	CCU	OTHER (SPECIFY)	
IMPATIENT - ALL PATIENTS	1	2	3	4	5
1 BEDS (EXCLUDING NEWBORN) AVAILABLE AT BEGINNING OF PERIOD	333	10	9	0	0
2 BEDS (EXCLUDING NEWBORN) AVAILABLE AT END OF PERIOD	343	10	9	0	0
3 TOTAL BED DAYS AVAILABLE (EXCLUDING NEWBORN)	121545	3650	3285	0	0
4 AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS	41214	863	994	0	0
5 OTHER THAN AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS (EXCLUDING NEWBORN)	41380	1500	753	0	0
6 TOTAL INPATIENT DAYS (EXCLUDING NEWBORN)	84594	2363	1747	0	0
7 PERCENT OCCUPANCY	69.60%	64.74%	53.18%	0.00%	0.00%
8 TOTAL NEWBORN INPATIENT DAYS	5828	----	----	----	----
INPATIENT - HEALTH CARE PROGRAMS	----	----	----	----	----
9 TITLE V	----	----	----	----	----
A INPATIENT DAYS (EXCLUDING NEWBORN)	0	0	0	0	0
B NEWBORN INPATIENT DAYS	0	----	----	----	----
10 TITLE XVIII	----	----	----	----	----
A AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS (EXCLUDING KIDNEY ACQUISITION DAYS)	27285	758	963	0	0
B KIDNEY ACQUISITION DAYS (AGED, PEDIATRIC, AND MATERNITY)	0	0	0	0	0
C TOTAL AGED, PEDIATRIC, AND MATERNITY INPATIENT DAYS	27285	758	963	0	0
D OTHER THAN AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS (EXCLUDING KIDNEY ACQUISITION DAYS)	4118	117	115	0	0
E KIDNEY ACQUISITION DAYS (OTHER THAN AGED, PEDIATRIC AND MATERNITY)	0	0	0	0	0
F TOTAL OTHER THAN AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS	4118	117	115	0	0
G TOTAL INPATIENT DAYS (EXCLUDING KIDNEY ACQUISITION DAYS)	31703	875	1078	0	0
H TOTAL KIDNEY ACQUISITION DAYS	0	0	0	0	0
I TOTAL PART A INPATIENT DAYS	31703	875	1078	0	0
J TOTAL PART B INPATIENT DAYS	31703	875	1078	0	0
K PART B INPATIENT DAYS WHEN PART A BENEFITS ARE NOT AVAILABLE	0	0	0	0	0
11 TITLE XIX	----	----	----	----	----
A INPATIENT DAYS (EXCLUDING NEWBORN)	0	0	0	0	0
B NEWBORN INPATIENT DAYS	0	----	----	----	----

OUTPATIENT - HEALTH CARE PROGRAMS	TITLE V	TITLE XVIII	TITLE XIX	ALL OTHER	TOTAL
12 NUMBER OF OCCASIONS OF SERVICE (EXCLUSIVE OF RENAL DIALYSIS TREATMENTS)	0	0	0	0	0

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ERNST & WHINNEY KOSTPAN SYSTEM
METHODIST HOSPITAL PROV # 16-0192 FYE 12/31/80 RUN DATE: 04/20/81
HOSPITAL AND HOSPITAL-SKILLED NURSING FACILITY COMPLEX
STATISTICAL DATA
SUBMITTED IN LIEU OF HCFA-2552- PAGE 3 (CONT'D)

PART III - OTHER HOSPITAL DATA

1 AMOUNT OF ACCELERATED PAYMENTS OUTSTANDING AS OF END OF COST REPORTING PERIOD - TITLE XVIII	0	0
2 AVERAGE NUMBER OF EMPLOYEES ON PAYROLL FOR THE PERIOD (FULL-TIME EQUIVALENT) - EXCLUDES NONPAID WORKERS		822
3 AVERAGE NUMBER OF NONPAID WORKERS FOR THE PERIOD (FULL-TIME EQUIVALENT) FOR WHICH REIMBURSEMENT IS CLAIMED		0
4 NUMBER OF RENAL DIALYSIS TREATMENTS (INPATIENT AND OUTPATIENT)		
A TOTAL - ALL HOSPITAL PATIENTS		0
B TITLE V		0
C TITLE XVIII		0
D TITLE XIX		0
5 NUMBER OF ADMISSIONS (EXCLUDING NEWBORN)		
A TOTAL - ALL HOSPITAL INPATIENTS		12711
B TITLE V		0
C TITLE XVIII		3312
D TITLE XIX		0
6 NUMBER OF DISCHARGES INCLUDING DEATHS (EXCLUDING NEWBORN)		
A TOTAL - ALL HOSPITAL INPATIENTS		12711
B TITLE V		
C TITLE XVIII		0
D TITLE XIX		0
7 AVERAGE LENGTH OF STAY		
A TOTAL		6.98
B TITLE V		0.00
C TITLE XVIII		.00
D TITLE XIX		0.00

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80 RUN DATE: 04/20/81
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
SUBMITTED IN LIEU OF HCFA-2552, PAGE 5 WORKSHEET A

EIN CST CTR NUM-BER	HCFA LINE NUM-BER	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS TO EXPENSES 6	NET EXPENSES FOR COST ALLOCATION 7
---	1	GENERAL SERVICE COST CENTERS	---	---	---	---	---	---	---
101	2	DEPRECIATION - BUILDINGS & FIXTURES	---	704935	704935	654762	1359697	0	1359697
102	3	DEPRECIATION - MOVABLE EQUIPMENT	---	526240	526240	0	526240	0	526240
103	4	EMPLOYEE HEALTH & WELFARE	76262	1143180	1219442	776	1220218	-84466	1135752
104	5A	NON-PATIENT TELEPHONES	33314	140545	173859	8000	181859	-25047	156812
105	5B	DATA PROCESSING	81475	59601	141076	0	141076	0	141076
106	5C	PURCHASING RECEIVING STORES	92059	47712	139771	0	139771	-12267	127504
107	5D	ADMITTING	85808	7035	92843	0	92843	0	92843
108	5E	CASHIER ACCOUNT RECEIVABLE COLLECTIONS	340370	120282	460652	0	460652	0	460652
109	5	OTHER ADMINISTRATIVE & GENERAL	264362	444838	709200	-23759	685441	-112890	572551
110	6	MAINTENANCE & REPAIRS	331749	231664	563413	0	563413	-197	563216
111	7	OPERATION OF PLANT	0	486401	486401	0	486401	-2519	483882
112	8	LAUNDRY & LINEN SERVICE	163031	114794	277825	0	277825	-76086	201739
113	9	HOUSEKEEPING	324821	180975	505796	0	505796	0	505796
114	10	DIETARY	513941	884526	1398467	-490335	908132	0	908132
115	11	CAFETERIA	0	0	0	490335	490335	-251513	238822
116	12	MAINTENANCE OF PERSONNEL	0	0	0	0	0	0	0
117	13	NURSING ADMINISTRATION	348081	20824	368905	0	368905	0	368905
118	14	CENTRAL SERVICES & SUPPLY	96837	275476	372313	0	372313	-8860	363453
119	15	PHARMACY	195309	660584	855893	-516493	339400	56799	282601
120	16	MEDICAL RECORDS & LIBRARY	186697	60792	247489	-6894	240595	-5798	234797
121	17	SOCIAL SERVICE	111229	8847	120076	-1938	118138	0	118138
122	18	NURSING SCHOOL	0	0	0	0	0	0	0
123	19	INTERN-RESIDENT SERVICE (APPROVED)	0	0	0	0	0	0	0
124	20	BLANK	0	0	0	0	0	0	0
---	21	ANCILLARY SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
125	22	OPERATING ROOM	358639	476777	835416	0	835416	-1975	833441
126	23	RECOVERY ROOM	0	0	0	0	0	0	0
127	24	DELIVERY ROOM & LABOR ROOM	188025	43399	231424	13573	244997	0	244997
128	25	ANESTHESIOLOGY	0	28039	28039	0	28039	0	28039
129	26	RADIOLOGY - DIAGNOSTIC	375591	284283	659874	66657	726531	-5446	721085
130	27	CAT SCAN	29176	170571	199747	7741	207488	-103356	104132
131	28	RADIOISOTOPE	35845	50293	86138	3960	90098	0	90098
132	29	LABORATORY	513872	498866	1012738	2992	1015730	-96312	921418
133	30	WHOLE BLOOD AND PACKED RED BLOOD CELLS	0	0	0	0	0	0	0
134	31	BLOOD STORING PROCESSING & TRANSFUSION	69719	45390	115109	0	115109	-146	114963
135	32	INTRAVENOUS THERAPY	0	71762	71762	0	71762	0	71762
136	33	OXYGEN (INHALATION) THERAPY	264982	80268	345250	0	345250	0	345250
137	34	PHYSICAL THERAPY	66144	3668	69812	0	69812	0	69812
138	35	OCCUPATIONAL THERAPY	89330	6187	95517	0	95517	0	95517
139	36	SPEECH PATHOLOGY	20802	6812	27614	0	27614	0	27614
140	37	ELECTROCARDIOLOGY	41689	14030	55719	0	55719	0	55719
141	38	ELECTROENCEPHALOGRAPHY	9290	21588	30878	0	30878	-18320	12558
142	39	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0
143	40	DRUGS CHARGED TO PATIENTS	0	0	0	516493	516493	0	516493
144	41	RENAL DIALYSIS	0	0	0	0	0	0	0
145	42	KIDNEY ACQUISITION	0	0	0	0	0	0	0
146	43	BLANK	0	0	0	0	0	0	0

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80 RUN DATE: 04/20/81
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
SUBMITTED IN LIEU OF HCFA-2552, PAGE 5 (CONT'D) WORKSHEET A

EIW CST CTR NBR	HCFA LINE NUMBER	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS TO EXPENSES 6	NET EXPENSES FOR COST ALLOCATION 7
---	45	INPATIENT ROUTINE SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
147	46	ADULTS & PEDIATRICS (GEN ROUTINE CARE)	334388	121627	3465516	-24391	3441125	0	3441125
148	47	INTENSIVE CARE UNIT	459544	29014	488558	0	488558	0	488558
149	48	CORONARY CARE UNIT	260126	12345	272471	0	272471	0	272471
150	51	NURSERY	150342	17256	167598	10818	178416	0	178416
151	52	SKILLED NURSING FACILITY - CERTIFIED	0	0	0	0	0	0	0
152	53	SKILLED NURSING FACILITY - NONCERTIFIED	0	0	0	0	0	0	0
153	53A	BLANK	0	0	0	0	0	0	0
---	54	OUTPATIENT SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
154	55	CLINIC	96781	95852	192633	-5179	187454	-13740	173714
155	56	EMERGENCY	384801	594279	979080	0	979080	-527664	451416
---	58	OTHER REIMBURSABLE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
156	59	HOME PROG. DIALYSIS OTHER	0	0	0	0	0	0	0
157	60	SKILLED NURSING CARE-HHA	0	0	0	0	0	0	0
158	61	MEDICAL SOCIAL SERVICES-HHA	0	0	0	0	0	0	0
159	62	HOME HEALTH AIDE - HHA	0	0	0	0	0	0	0
160	63	OTHER HOME HEALTH SERVICES - HHA	0	0	0	0	0	0	0
161	64	HOME PROG DIALYSIS EQUIP-100% MEDICARE	0	0	0	0	0	0	0
162	65	AMBULANCE SERVICES	0	0	0	0	0	0	0
163	66	INTERNS-RESIDENTS (NOT APPROVED)	0	0	0	0	0	0	0
164	67	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	0	0	0	0	0
165	68	INTEREST EXPENSE	0	720238	720238	-720238	0	0	0
166	69	UTILIZATION REVIEW - SNF	0	0	0	0	0	0	0
167	70	PSRO-FEDERAL OR COMBINED	33868	53	33921	13120	47041	-47041	0
168	71	PSRO - NONFEDERAL	0	0	0	0	0	0	0
---	73	SUBTOTAL	10059800	9491848	19551648	0	19551648	-1450442	18101206
---	74	NONREIMBURSABLE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
169	75	GIFT FLOWER COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0
170	76	RESEARCH	0	0	0	0	0	0	0
171	77	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	0
172	78	NONPAID WORKERS	0	0	0	0	0	0	0
---	80	TOTAL	10059800	9491848	19551648	0	19551648	-1450442	18101206

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80
ADJUSTMENTS TO EXPENSES
SUBMITTED IN LIEU OF HCFA-2552, PAGE 11

RUN DATE: 04/20/81

WORKSHEET A-8

	DESCRIPTION	BASIS FOR ADJUST-MENT 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED: COST CENTER 3	HCFA LINE NO. 4	E&W COST CTR NO.
1	INVESTMENT INCOME ON COMMINGLED RESTRICTED AND UNRESTRICTED FUNDS (CHAPTER 2)		$ 0			0
2	TRADE, QUANTITY, TIME AND DISCOUNTS ON PURCHASES (CHAPTER 8)	B	-10992	PURCHASING RECEIVING STORES	5C	106
3	REBATES AND REFUNDS OF EXPENSES (CHAPTER 8)		0			0
4	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 9)		0			0
5	TELEPHONE SERVICE (PAY STATIONS EXCLUDED) (CHAPTER 21)	A	-25047	NON-PATIENT TELEPHONES	5A	104
6	TELEVISION AND RADIO SERVICE (CHAPTER 21)		0			0
7	PARKING LOT (CHAPTER 21)		0			0
8	REMUNERATION APPLICABLE TO PROVIDER-BASED RADIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)		0			0
9	REMUNERATION APPLICABLE TO PROVIDER-BASED PATHOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)	A	-91169	LABORATORY	29	132
10	REMUNERATION APPLICABLE TO PROVIDER-BASED ANESTHESIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)		0			0
11	REMUNERATION APPLICABLE TO PROVIDER-BASED CARDIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)		0			0
12	REMUNERATION APPLICABLE TO PROVIDER-BASED NEUROLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)	A	-18320	ELECTROENCEPHALOGRAPHY	38	141
13	RADIOLOGY - THERAPEUTIC		0			0
14	RADIOISOTOPE		0			0
15	NUCLEAR MEDICINE		0			0
16	MISC. REVENUES	B	-123	OTHER ADMINISTRATIVE & GENERAL	5	109
17	HOME OFFICE COSTS (CHAPTER 21)		0			0
18	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)		0			0
19	NONALLOWABLE COSTS RELATED TO CERTAIN CAPITAL EXPENDITURES (CHAPTER 24)		0			0
20	ADJUSTMENT RESULTING FROM TRANSACTIONS WITH RELATED ORGANIZATIONS (CHAPTER 10)		0			0
21	LAUNDRY AND LINEN SERVICE	B	-76086	LAUNDRY & LINEN SERVICE	8	112
22	CAFETERIA - EMPLOYEES, GUESTS, ETC.	B	-251513	CAFETERIA	11	115
23	RENTAL OF LIVING QUARTERS TO EMPLOYEES AND OTHERS	B	-9330	OTHER ADMINISTRATIVE & GENERAL	5	109
24	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		0			0
25	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-56799	PHARMACY	15	119
26	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-5062	MEDICAL RECORDS & LIBRARY	16	120
27	NURSING SCHOOL (TUITION, FEES, TEXTBOOKS, UNIFORMS, ETC.)		0			0
28	VENDING MACHINES	B	-2519	OPERATION OF PLANT	7	111
29	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)		0			0
30	XEROX SALES	B	-1275	PURCHASING RECEIVING STORES	5C	106
31	PSRO COST	A	-47041	PSRO-FEDERAL OR COMBINED	70	167
32	SUBTOTAL	---	$ -595276			

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80
ADJUSTMENTS TO EXPENSES
SUBMITTED IN LIEU OF HCFA-2552, PAGE 12

RUN DATE: 04/20/81

WORKSHEET A-8

	DESCRIPTION	BASIS FOR ADJUSTMENT 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED — COST CENTER 3	HCFA LINE NO. 4	E&W COST CTR NO.
33	SUBTOTAL	---	$ -595276			
34	ADJUSTMENTS FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)		0			0
35	MALPRACTICE PREMIUMS AND/OR SELF-INS. FUND CONTRIBUTIONS (CHAPTER 21)	A	-377217	OTHER ADMINISTRATIVE & GENERAL	5	109
36	ALLOWABLE PAID TITLE XVIII MALPRACTICE LOSSES (CHAPTER 21)		0			0
37	ALLOWABLE RELATED DIRECT EXPENSES TO PAID TITLE XVIII MALPRACTICE LOSSES (CHAPTER 21)		0			0
38	ALLOWABLE PAID TITLE XIX MALPRACTICE LOSSES (CHAPTER 21)		0			0
39	ALLOWABLE RELATED DIRECT EXPENSES TO PAID TITLE XIX MALPRACTICE LOSSES (CHAPTER 21)		0			0
40	ALLOWABLE PAID TITLE V MALPRACTICE LOSSES (CHAPTER 21)		0			0
41	ALLOWABLE RELATED DIRECT EXPENSES TO PAID TITLE V MALPRACTICE LOSSES (CHAPTER 21)		0			0
42	ALLOWABLE PAID MALPRACTICE LOSSES AND RELATED DIRECT EXPENSES APPLICABLE TO THE HOME HEALTH AGENCY		0			0
43	NONALLOWABLE MALPRACTICE PREMIUMS, PAID LOSSES AND RELATED EXPENSES (CHAPTER 21)		0			0
44			0			0
45	PSRO COSTS (FEDERAL OR COMBINED) (PRM, PART I, 1975 AMENDMENTS)		0			0
46	PSRO COSTS (NON-FEDERAL ONLY) (PRM, PART I, 1975 AMENDMENTS)		0			0
47	CONT.MED.EDUC.	B	-736	MEDICAL RECORDS & LIBRARY	16	120
48	MISC-MAINTENANCE	B	-197	MAINTENANCE & REPAIRS	6	110
49	MISC-OR	B	-1975	OPERATING ROOM	22	125
50	MISC-BLOOD	B	-146	BLOOD STORING PROCESSING & TRANSFUSION	31	134
51	MISC-LAB	B	-5143	LABORATORY	29	132
52	PATHOLOGIST FRINGES	B	-839	EMPLOYEE HEALTH & WELFARE	4	103
53	MISC-SUPPLY	B	-8860	CENTRAL SERVICES & SUPPLY	14	118
54	RECRUITING COST	B	-12771	OTHER ADMINISTRATIVE & GENERAL	5	109
55	RECRUITING COST	B	-17500	EMPLOYEE HEALTH & WELFARE	4	103
56	SILVER RECOVERY(AT COST)	A	-5446	RADIOLOGY - DIAGNOSTIC	26	129
57	CAT SCAN HBP	A	-103356	CAT SCAN	27	130
57A	ER PHYSICIANS	A	-527664	EMERGENCY	56	155
57B	GAIN ON DISP OF ASSET	B	-949	OTHER ADMINISTRATIVE & GENERAL	5	109
57C	SELF-INS HOSPITAL	A	-66127	EMPLOYEE HEALTH & WELFARE	4	103
57D	PURCHSED LAB SVCS	A	-13740	CLINIC	55	154
57E	MALPRACTICE INS FUNDING	A	287500	OTHER ADMINISTRATIVE & GENERAL	5	109
58	SUBTOTAL	---	$ -1450442			
59	GRANTS, GIFTS, AND INCOME DESIGNATED BY DONOR FOR SPECIFIC EXPENSES (CHAPTER 6)		0			0
60	UTILIZATION REVIEW - PHYSICIANS' COMPENSATION (CHAPTER 21)		0			0
61	DEPRECIATION - BUILDINGS AND FIXTURES		0			0

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80 RUN DATE: 04/20/81
ADJUSTMENTS TO EXPENSES
SUBMITTED IN LIEU OF HCFA-2552, PAGE 12 (CONT'D) WORKSHEET A-8

	DESCRIPTION	BASIS FOR ADJUST-MENT 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED — COST CENTER 3	HCFA LINE NO. 4	E&W COST CTR NO.
62	DEPRECIATION - MOVABLE EQUIPMENT		0			0
63			0			0
64	TOTAL	---	$ -1450442	----------		

BASIS FOR ADJUSTMENT
A. COSTS--IF COST, INCLUDING APPLICABLE OVERHEAD, CAN BE DETERMINED.
B. AMOUNT RECEIVED--IF COST CANNOT BE DETERMINED.

43a

14

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION
Title omitted in printing.

Plaintiffs' Opposition To
Defendant's Second Motion To Dismiss
Attachment B-2

Excerpts from FYE 1980 Cost Report
DEACONESS HOSPITAL

45a

Form Approved
OMB No. 68-R0078

WORKSHEET CHECKLIST FOR HOSPITAL, HOSPITAL-SKILLED NURSING FACILITY COMPLEX AND SKILLED NURSING FACILITY COST REPORT

PROVIDER NO. 54-0038 | PERIOD 1 FROM 1-1-79 TO 12-31-79

	CHECK THE APPROPRIATE COLUMN FOR EACH WORKSHEET	Completed: HCFA Worksheet	Completed: Substitute Worksheet	Not Applicable
	WORKSHEETS	1	2	3
1	Worksheet Checklist	✓		
2	Hospital and Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Statistical Data – Part I	✓		
3	Hospital and Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Statistical Data – Parts II and III		✓	
4	Hospital and Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Statistical Data – Parts IV and V	✓		
5	Worksheet A		✓	
6	Worksheet A-1		✓	
7	Worksheet A-2		✓	
8	Worksheet A-3		✓	
9	Worksheet A-4		✓	
10	Worksheet A-5		✓	
11	Worksheet A-6		✓	
12	Worksheet A-7	✓		
13	Worksheet A-8		✓	
14	Worksheet A-8-1	✓		
15	Worksheet A-8-2	✓		
16	Worksheet B		✓	
17	Worksheet B-1		✓	
18	Worksheet C		✓	
19	Worksheet D		✓	
20	Worksheet D-1 – Part I (All Pages Must Be Completed)		✓	
21	Worksheet D-1 – Part II		✓	
22	Worksheet D-2	✓		
23	Worksheet D-3		✓	
24	Worksheet D-4		✓	
25	Worksheet E – Part I		✓	
26	Worksheet E – Part II		✓	
27	Worksheet E – Part III		✓	
28	Worksheet E-1	✓		
29	Worksheet E-2		✓	
30	Worksheet E-5 – Parts I and II	✓		
31	Worksheet E-5 – Part III	✓		
32	Worksheet G	✓		
33	Worksheet G-1	✓		
34	Worksheet G-2	✓		
35	Worksheet G-3	✓		

SUPPLEMENTAL WORKSHEETS (AVAILABLE UPON REQUEST FROM INTEMEDIARY)

36	HCFA-2562A – Supplemental Worksheet D-4			
37	HCFA-2562A – Supplemental Worksheet D-5			
38	HCFA-2562B – Supplemental Worksheet D-6			
39	HCFA-2562C – Supplemental Worksheet D-7			
40	HCFA-2562D – Supplemental Worksheet E-3			
41	HCFA-2562E – Supplemental Worksheet E-4			
42	HCFA-2562F – Supplemental Worksheet E-4-1			
43	HCFA-2562G – Supplemental Worksheet F – Part I			
44	HCFA-2562G – Supplemental Worksheet F – Part II			
45	HCFA-2562G – Supplemental Worksheet F – Part III			
46	HCFA-2562H – Supplemental Worksheet A-8-3			

If substitute worksheets are a part or all of this cost report (a check in column 2), enter the name and address of the person, company or forms preparation service which originated the substitute worksheets:

NAME : KOSTPAK ERNST & WHINNEY

ADDRESS: 1400 DIGIS TOWER

CINCINNATI, OHIO 45202

Form HCFA-2552 (5-80)
Destroy old issue

This report is required by law (42 USC 1395g, 20 CFR 405.406[b]). Failure to report can result in all interim payments made since the beginning of the cost report period being deemed overpayments (42 USC 1395g).

Form Approved
OMB No. 68-R0078

HOSPITAL, HOSPITAL-SKILLED NURSING FACILITY COMPLEX AND SKILLED NURSING FACILITY STATISTICAL DATA	INTERMEDIARY USE ONLY ☐ AUDITED ☐ DESK REVIEWED	DATE RECEIVED / INTERMEDIARY NO.

PART I – GENERAL

1. Names and Addresses	Provider Numbers	Dates Certified
HOSPITAL THE DEACONESS HOSPITAL	36-0038	7-1-66
SUBPROVIDER I		
SUBPROVIDER II		
SKILLED NURSING FACILITY		
HOME HEALTH AGENCY		
SPECIAL PROVIDER-CONTROLLED FACILITY		

2. Cost Reporting Period — From 1-1-80 TO 12-31-80

3. Type of Control

a. Voluntary Nonprofit
- ☐ Church
- ☑ Other (Specify) CORPORATION

b. Proprietary
- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Other (Specify)

c. Government
- ☐ Federal
- ☐ State
- ☐ Other (Specify)
- ☐ City-County
- ☐ Hospital District
- ☐ County
- ☐ City

4. Type of Hospital

a.
- ☑ General-Short Term
- ☐ General-Long Term
- ☐ Tuberculosis
- ☐ Specialty Short-Term
- ☐ Specialty Long-Term
- ☐ Chronic Disease
- ☐ Psychiatric
- ☐ Other (Specify) _____

b. Medicare Certified Kidney Transplant Hospital — ☐ Yes ☑ No

5. Type of Skilled Nursing Facility
- ☐ Entirely Certified Skilled Nursing Facility
- ☐ Partially Certified Skilled Nursing Facility
- ☐ Skilled Nursing Facility Unit of Domiciliary Institution
- ☐ Skilled Nursing Facility Unit of Rehabilitation Center
- ☐ Other (Specify)

6. Health Care Programs — ☑ Title V ☑ Title XVIII ☑ Title XIX

7. a. Are management and/or administrative support services purchased from an outside supplier or organization? OHMS - A&A — ☑ Yes ☐ No

b. If yes, what is the total amount for these services included on Worksheet A, column 7? $ [illegible]

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Statement of Reimbursable Cost and the Balance Sheet and Statement of Revenue and Expense prepared by THE DEACONESS HOSPITAL 36-0038 (Provider name(s) and number(s)) for the cost report period beginning 1-1-80 and ending 12-31-80, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted. THE ATTACHED NOTES ARE AN INTEGRAL PART OF THIS REPORT AS PRESENTED.

(Signed) _____
Officer or Administrator of Provider(s)

Title ASSISTANT ADMINISTRATOR - FINANCE

Date

BEST AVAILABLE COPY

ERNST [illegible] HOSPITAL SYSTEM
DEACON [illegible] HOSPITAL PROV ID 36-0039 FROM 01/01/80 TO 12/31/80 RUN DATE: 04/16/81
HOSPITAL AND HOSPITAL-SKILLED NURSING FACILITY COMPLEX
STATISTICAL DATA
SUBMITTED IN LIEU OF HCFA-2552, PAGE 3

PART II - HOSPITAL STATISTICS

		SPECIAL CARE UNITS			
					OTHER (SPECIFY)
		GENERAL SERVICE	ICU	CCU	
	INPATIENT - ALL PATIENTS	1	2	3	4	5
1	BEDS (EXCLUDING NEWBORN) AVAILABLE AT BEGINNING OF PERIOD	266	6	6	0	0
2	BEDS (EXCLUDING NEWBORN) AVAILABLE AT END OF PERIOD	266	6	6	0	0
3	TOTAL BED DAYS AVAILABLE (EXCLUDING NEWBORN)	97356	2196	2196	0	0
4	AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS	42861	1080	917	0	0
5	OTHER THAN AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS (EXCLUDING NEWBORN)	38287	587	545	0	0
6	TOTAL INPATIENT DAYS (EXCLUDING NEWBORN)	81148	1667	1462	0	0
7	PERCENT OCCUPANCY	83.35%	75.91%	66.58%	0.00%	0.00%
8	TOTAL NEWBORN INPATIENT DAYS	0	-----	-----	-----	-----
	INPATIENT - HEALTH CARE PROGRAMS	-----	-----	-----	-----	-----
9	TITLE V	-----	-----	-----	-----	-----
	A INPATIENT DAYS (EXCLUDING NEWBORN)	0	0	0	0	0
	B NEWBORN INPATIENT DAYS	0	-----	-----	-----	-----
10	TITLE XVIII	-----	-----	-----	-----	-----
	A AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS (EXCLUDING KIDNEY ACQUISITION DAYS)	39567	1012	842	0	0
	B KIDNEY ACQUISITION DAYS (AGED, PEDIATRIC, AND MATERNITY)	0	0	0	0	0
	C TOTAL AGED, PEDIATRIC, AND MATERNITY INPATIENT DAYS	39567	1012	842	0	0
	D OTHER THAN AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS (EXCLUDING KIDNEY ACQUISITION DAYS)	2295	47	45	0	0
	E KIDNEY ACQUISITION DAYS (OTHER THAN AGED, PEDIATRIC AND MATERNITY)	0	0	0	0	0
	F TOTAL OTHER THAN AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS	2295	47	45	0	0
	G TOTAL INPATIENT DAYS (EXCLUDING KIDNEY ACQUISITION DAYS)	41862	1059	887	0	0
	H TOTAL KIDNEY ACQUISITION DAYS	0	0	0	0	0
	I TOTAL PART A INPATIENT DAYS	41862	1059	887	0	0
	J TOTAL PART B INPATIENT DAYS	0	0	0	0	0
	K PART B INPATIENT DAYS WHEN PART A BENEFITS ARE NOT AVAILABLE	661	0	0	0	0
11	TITLE XIX	-----	-----	-----	-----	-----
	A INPATIENT DAYS (EXCLUDING NEWBORN)	0	0	0	0	0
	B NEWBORN INPATIENT DAYS	0	-----	-----	-----	-----

	OUTPATIENT - HEALTH CARE PROGRAMS	TITLE V	TITLE XVIII	TITLE XIX	ALL OTHER	TOTAL
12	NUMBER OF OCCASIONS OF SERVICE (EXCLUSIVE OF RENAL DIALYSIS TREATMENTS)	0	6576	0	44986	51562

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[illegible] PROVIDER [illegible] PERIOD FROM 01/01/80 TO 12/31/80 RUN DATE: 04/16/81
HOSPITAL AND HOSPITAL-SKILLED NURSING FACILITY COMPLEX
STATISTICAL DATA
SUBMITTED IN LIEU OF HCFA-2552, PAGE 3 (CONTD)

PART III - OTHER HOSPITAL DATA

1 AMOUNT OF ACCELERATED PAYMENTS OUTSTANDING AS OF END OF COST REPORTING PERIOD - TITLE XVIII $	0
2 AVERAGE NUMBER OF EMPLOYEES ON PAYROLL FOR THE PERIOD (FULL-TIME EQUIVALENT) - EXCLUDES NONPAID WORKERS	723
3 AVERAGE NUMBER OF NONPAID WORKERS FOR THE PERIOD (FULL-TIME EQUIVALENT) FOR WHICH REIMBURSEMENT IS CLAIMED	0
4 NUMBER OF RENAL DIALYSIS TREATMENTS (INPATIENT AND OUTPATIENT)	
A TOTAL - ALL HOSPITAL PATIENTS	0
B TITLE V	0
C TITLE XVIII	0
D TITLE XIX	0
5 NUMBER OF ADMISSIONS (EXCLUDING NEWBORN)	10337
A TOTAL - ALL HOSPITAL INPATIENTS	0
B TITLE V	3913
C TITLE XVIII	0
D TITLE XIX	0
6 NUMBER OF DISCHARGES INCLUDING DEATHS (EXCLUDING NEWBORN)	10365
A TOTAL - ALL HOSPITAL INPATIENTS	0
B TITLE V	3910
C TITLE XVIII	0
D TITLE XIX	0
7 AVERAGE LENGTH OF STAY	8.16
A TOTAL	0.00
B TITLE V	11.20
C TITLE XVIII	0.00
D TITLE XIX	

HOSPITAL, HOSPITAL-SKILLED NURSING FACILITY COMPLEX AND SKILLED NURSING FACILITY STATISTICAL DATA	PROVIDER NO. 36-0038	PERIOD: FROM 1-1-80 TO 12-31-80

PART IV - SUBPROVIDER AND SKILLED NURSING FACILITY STATISTICS

	INPATIENT - ALL PATIENTS	SUBPROVIDER I	SUBPROVIDER II	SKILLED NURSING FAC - TY CERTIFIED PORTION	SKILLED NURSING FAC - TY NONCERTIFIED PORTION
		1	2	3	4
1	Beds (excluding newborn) available at beginning of period	N/A	N/A	N/A	N/A
2	Beds (excluding newborn) available at end of period				
3	Total bed days available (excluding newborn)				
4	Aged, pediatric and maternity inpatient days				
5	Other than aged, pediatric and maternity inpatient days (excluding newborn)				
6	Total inpatient days (excluding newborn) (Sum of lines 4 and 5)				
7	Percent occupancy (line 6 ÷ line 3)	%	%	%	%
8	Total newborn inpatient days				
	INPATIENT - HEALTH CARE PROGRAMS				
9	TITLE V				
	a. Inpatient days (excluding newborn)				
	b. Newborn inpatient days				
10	TITLE XVIII				
	a. Aged, pediatric and maternity inpatient days (excluding kidney transplant days)				
	b. Kidney transplant days (aged, pediatric and maternity)				
	c. Total aged, pediatric and maternity inpatient days (Sum of lines 10a and 10b)				
	d. Other than aged, pediatric and maternity inpatient days (excluding kidney transplant days)				
	e. Kidney transplant days (other than aged, pediatric and maternity)				
	f. Total other than aged, pediatric and maternity inpatient days (Sum of lines 10d and 10e)				
	g. Total inpatient days (excluding kidney transplant days) (Sum of lines 10c and 10d)				
	h. Total kidney transplant days (Sum of lines 10b and 10e)				
	i. Total Part A inpatient days (Sum of lines 10g and 10h)				
	j. Total Part B inpatient days (SEE INSTRUCTIONS)				
	k. Part B inpatient days where Part A benefits are not available (SEE INSTRUCTIONS)				
11	TITLE XIX				
	a. Inpatient days (excluding newborn)				
	b. Newborn inpatient days				

PART V - OTHER SUBPROVIDER AND SKILLED NURSING FACILITY DATA

		SUBPROVIDER I	SUBPROVIDER II	SKILLED NURS FACILITY
1	Amount of accelerated payments outstanding as of end of last reporting period - Title XVIII	$ 0	$ 0	$ 0
2	Average number of employees on payroll for the period (full-time equiv.) - exclude unpaid workers			
3	Average number of unpaid workers for the period (full-time equiv.) for which reimbursement is claimed			
4	Number of occasions of service - OUTPATIENTS (exclusive of renal dialysis treatments)			
	a. Total - All OUTPATIENTS			
	b. Title V			
	c. Title XVIII			
	d. Title XIX			
5	Number of renal dialysis treatments			
	a. Total - All PATIENTS			
	b. Title V			
	c. Title XVIII			
	d. Title XIX			
6	Number of admissions (excluding newborn)			
	a. Total - All inpatients			
	b. Title V			
	c. Title XVIII			
	d. Title XIX			
7	Number of discharges including deaths (excluding newborn)			
	a. Total - All inpatients			
	b. Title V			
	c. Title XVIII			
	d. Title XIX			
8	Average length of stay			
	a. Total (Part IV, line 6 ÷ Part V, line 7a)			
	b. Title V (Part IV, line 8a ÷ Part V, line 7b)			
	c. Title XVIII (Part IV, line 10c ÷ Part V, line 7c)			
	d. Title XIX (Part IV, line 11a ÷ Part V, line 7d)			

Form HCFA-2552 (5-80)

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[illegible] SYSTEM
PEACON HOSPITAL PROV NO 36-0039 FROM 01/01/80 TO 12/31/80 RUN DATE: 04/15/81
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
SUBMITTED IN LIEU OF HCFA-2552a PAGE 5 WORKSHEET A

E&W HCFA CST LINE CTR NUM-NBR NEW	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS TO EXPENSES 6	NET EXPENSES FOR COST ALLOCATION 7
--- 1	REVENUE SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
101 2	DEPRECIATION-BUILDING	-----	818212	818212	1225854	2044066	-198362	1845704
102 3	DEPRECIATION-EQUIPMENT	-----	457381	457381	0	457381	0	457381
103 4	EMPLOYEE HEALTH AND WELFARE	0	0	0	230761	230761	0	230761
104 5	OTHER ADMINISTRATIVE	1054969	2739719	3794688	-1669999	2126590	318126	2444716
105 6A	PARKING GARAGE	74506	19249	93755	-29923	63832	-63832	0
106 7A	PLANT & MAINTENANCE	451166	1096193	1547359	0	1547359	-3154	1544205
107 8	LAUNDRY & LINEN	195758	254275	450033	0	450033	0	450033
108 9	HOUSEKEEPING	500252	231877	732129	0	732129	0	732129
109 10	DIETARY	686558	811028	1497586	-492403	1005183	0	1005183
110 11	CAFETERIA	0	0	0	492403	492403	0	492403
111 13	NURSING ADMINISTRATION	301673	78762	380435	0	380435	0	380435
112 14	MEDICAL SUPPLIES	176315	834103	1010418	-794344	216074	-521	215553
113 15	PHARMACY	314841	776973	1091814	0	1091814	-21911	1069903
114 16	MEDICAL RECORDS	195419	105788	301207	-1517	299690	-9223	290467
115 17	SOCIAL SERVICE	101994	23039	125733	-23490	102243	0	102243
116 18	NURSING SCHOOL	377444	140459	517903	0	517903	-96184	421719
117 20A	BLANK	0	0	0	0	0	0	0
118 20B	BLANK	0	0	0	0	0	0	0
119 20C	BLANK	0	0	0	0	0	0	0
--- 21	ANCILLARY SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
120 22A	SURGERY & RECOVERY	707142	409230	1116372	0	1116372	0	1116372
121 37	E K G	53244	96793	150037	0	150037	-74086	75951
122 43A	E E G	2012	53943	55955	0	55955	-52692	3263
123 25	ANESTHESIA	0	80067	80067	0	80067	0	80067
124 28	RADIOLOGY	381189	1144105	1525294	0	1525294	-479163	1046131
125 29	LABORATORY	529154	868602	1397756	0	1397756	-173381	1224375
126 30	BLOOD	0	71858	71858	0	71858	0	71858
127 31	E E G	12951	26654	39605	0	39605	-15557	24048
128 33	OXYGEN THERAPY	161860	60429	222289	0	222289	0	222289
129 34	PHYSICAL THERAPY	109794	27324	137118	0	137118	0	137118
130 35	COST OF MEDICAL SUPPLIES SOLD	0	0	0	794344	794344	0	794344
131 40	COST OF DRUGS SOLD	0	0	0	0	0	0	0
132 43A	PULMONARY FUNCTION	12750	13933	26283	0	26283	-7820	18463
133 43B	B B G	1829	2795	4624	0	4624	-1904	2720
134 43C	STRESS TEST	3693	10782	14475	0	14475	-9491	4984
135 43D	HOLTER MONITOR	10205	24967	35172	0	35172	-21774	13398
136 43F	BLANK	0	0	0	0	0	0	0
137 43F	BLANK	0	0	0	0	0	0	0
138 43G	BLANK	0	0	0	0	0	0	0
--- 45	INPATIENT ROUTINE SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
139 46	ROUTINE INPATIENT	3297301	748529	4045830	0	4045830	0	4045830
140 47	I C U	232867	65143	298010	0	298010	0	298010
141 48	C C U	202964	42809	245773	0	245773	0	245773
142 48A	BLANK	0	0	0	0	0	0	0
143 48B	BLANK	0	0	0	0	0	0	0

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FORM [illegible]
HEADER [illegible] FROM 01/01/90 TO 12/31/90 RUN DATE: 04/16/91
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
SUBSTITUTE IN LIEU OF HCFA-2552A PAGE 5 (CONTINUED) WORKSHEET A

RAW HCFA CST CTR NUM-BER	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS TO EXPENSES 6	NET EXPENSES FOR COST ALLOCATION 7
--- 54	OUTPATIENT SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
145 56	EMERGENCY	218572	324512	543084	0	543084	-256114	286970
146 56A	BLANK	0	0	0	0	0	0	0
147 56P	BLANK	0	0	0	0	0	0	0
--- 58	OTHER REIMBURSABLE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
148 66A	HOUSE PHYSICIANS	68224	443384	512608	0	512608	0	512608
149 69A	UTILIZATION REVIEW	0	0	0	25007	25007	-25007	0
150 67	MALPRACTICE	0	0	0	243306	243306	-243306	0
151 65A	BLANK	0	0	0	0	0	0	0
152 65P	BLANK	0	0	0	0	0	0	0
--- 73	SUBTOTAL	10454046	12893717	23347763	0	23347763	-1440356	21907407
--- 74	NONREIMBURSABLE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
153 75	GIFT SHOP	0	0	0	0	0	0	0
154 7HA	RENTED SPACE	0	0	0	0	0	0	0
155 7HH	BLANK	0	0	0	0	0	0	0
156 7HC	BLANK	0	0	0	0	0	0	0
157 7HD	BLANK	0	0	0	0	0	0	0
158 7HE	BLANK	0	0	0	0	0	0	0
159 7HF	BLANK	0	0	0	0	0	0	0
160 7HG	BLANK	0	0	0	0	0	0	0
161 7HH	BLANK	0	0	0	0	0	0	0
162 7HI	BLANK	0	0	0	0	0	0	0
163 7HJ	BLANK	0	0	0	0	0	0	0
164 7HK	BLANK	0	0	0	0	0	0	0
165 7HL	BLANK	0	0	0	0	0	0	0
166 7HM	BLANK	0	0	0	0	0	0	0
167 7HN	BLANK	0	0	0	0	0	0	0
168 7HO	BLANK	0	0	0	0	0	0	0
169 7HP	BLANK	0	0	0	0	0	0	0
170 7HQ	BLANK	0	0	0	0	0	0	0
171 7HW	BLANK	0	0	0	0	0	0	0
172 7HZ	BLANK	0	0	0	0	0	0	0
--- 80	TOTAL	10454046	12893717	23347763	0	23347763	-1440356	21907407

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[illegible] RUN DATE: 04/16/91

ADJUSTMENTS TO EXPENSES

SUBMITTED IN LIEU OF HCFA-2552, PAGE 11

WORKSHEET A-8

	DESCRIPTION	BASIS FOR ADJUST-MENT		AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED: COST CENTER	HCFA LINE NO.	ESC COST CTR NO.
		1		2	3	4	
1	INVESTMENT INCOME ON COMMINGLED RESTRICTED AND UNRESTRICTED FUNDS (CHAPTER 2)	B	$	-143343	DEPRECIATION-BUILDING	2	101
2	STAFF, QUANTITY, TIME AND DISCOUNTS ON PURCHASES (CHAPTER 9)	B		-9599	OTHER ADMINISTRATIVE	5	104
3	REBATES AND REFUNDS OF EXPENSES (CHAPTER 61			0			0
4	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)			0			0
5	TELEPHONE SERVICE (PAY STATIONS EXCLUDED) (CHAPTER 21)	A		-84869	OTHER ADMINISTRATIVE	5	104
6	TELEVISION AND RADIO SERVICE (CHAPTER 21)	A		-196	PLANT & MAINTENANCE	7A	104
7	PARKING LOT (CHAPTER 21)	H		-68832	PARKING GARAGE	6A	103
8	RECLASSIFICATION APPLICABLE TO PROVIDER-BASED RADIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)	A		-479163	RADIOLOGY	28A	124
9	RECLASSIFICATION APPLICABLE TO PROVIDER-BASED PATHOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)	A		-173381	LABORATORY	29	125
10	RECLASSIFICATION APPLICABLE TO PROVIDER-BASED ANESTHESIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)			0			0
11	RECLASSIFICATION APPLICABLE TO PROVIDER-BASED CARDIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)	A		-74086	E K G	37	121
12	RECLASSIFICATION APPLICABLE TO PROVIDER-BASED RADIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)	A		-15557	E E G	38	127
13	RADIOLOGY - THERAPEUTIC			0			0
14	RADIOISOTOPE			0			0
15	NUCLEAR MEDICINE			0			0
16	PULMONARY FUNCTION	A		-7828	PULMONARY FUNCTION	43A	132
17	HOME OFFICE COSTS (CHAPTER 21)			0			0
18	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)			0			0
19	NONALLOWABLE COSTS RELATED TO CERTAIN CAPITAL EXPENDITURES (CHAPTER 24)			0			0
20	ADJUSTMENT RESULTING FROM TRANSACTIONS WITH RELATED ORGANIZATIONS (CHAPTER 10)			0			0
21	LIBRARY AND LIBRARY SERVICE			0			0
22	CAFETERIA - EMPLOYEES, GUESTS, ETC.			0			0
23	RENTAL OF LIVING QUARTERS TO EMPLOYEES AND OTHERS			0			0
24	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	H		-521	MEDICAL SUPPLIES	14	112
25	SALE OF DRUGS TO OTHER THAN PATIENTS	H		-21911	PHARMACY	15	113
26	SALE OF MEDICAL RECORDS AND ABSTRACTS	H		-9223	MEDICAL RECORDS	16	114
27	NURSING SCHOOL (TUITION, FEES, TEXTBOOKS, UNIFORMS, ETC.)	H		-96196	NURSING SCHOOL	18	116
28	[illegible]	H		-2958	PLANT & MAINTENANCE	7A	104
29	INCOME FROM DEPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)			0			0
30	ADD	A		-52692	E M G	43A	122
31	ADD	A		-1984	P R G	43B	133

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WORKSHEET A-8

	DESCRIPTION	BASIS FOR ADJUST-MENT	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED: COST CENTER	HCFA LINE NO.	HCFA COST CTR NO.
		1	2	3	4	
33	SUBTOTAL	---	$ -1242239			
34	ADJUSTMENTS FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)		0			0
35	MALPRACTICE PREMIUMS AND/OR SELF-INS. FUND CONTRIBUTIONS (CHAPTER 21)	A	-243306	MALPRACTICE	67	156
36	ALLOWABLE PAID TITLE XVIII MALPRACTICE LOSSES (CHAPTER 21)		0			0
37	ALLOWABLE RELATED DIRECT EXPENSES TO PAID TITLE XVIII MALPRACTICE LOSSES (CHAPTER 21)		0			0
38	ALLOWABLE PAID TITLE XIX MALPRACTICE LOSSES (CHAPTER 21)		0			0
39	ALLOWABLE RELATED DIRECT EXPENSES TO PAID TITLE XIX MALPRACTICE LOSSES (CHAPTER 21)		0			0
40	ALLOWABLE PAID TITLE V MALPRACTICE LOSSES (CHAPTER 21)		0			0
41	ALLOWABLE RELATED DIRECT EXPENSES TO PAID TITLE V MALPRACTICE LOSSES (CHAPTER 21)		0			0
42	ALLOWABLE PAID MALPRACTICE LOSSES AND RELATED DIRECT EXPENSES APPLICABLE TO THE HOME HEALTH AGENCY		0			0
43	NONALLOWABLE MALPRACTICE PREMIUMS, PAID LOSSES AND RELATED EXPENSES (CHAPTER 21)		0			0
44			0			0
45	PSRO COSTS (FEDERAL OR COMBINED) (P.L. 93-641, PART I, 1975 AMENDMENTS)		0			0
46	PSRO COSTS (NON-FEDERAL ONLY) (P.L. 93-641, PART I, 1975 AMENDMENTS)		0			0
47	EMERGENCY ROOM	A	-256114	EMERGENCY	56	145
48	LOSS ON DISPOSALS	A	1408	DEPRECIATION-BUILDING	2	101
49	BAD DEBTS	A	391361	OTHER ADMINISTRATIVE	5	104
50	CHARITY	A	884	OTHER ADMINISTRATIVE	5	104
51	PSRO COSTS	A	-25007	UTILIZATION REVIEW	69A	149
52	UNEMPLOYMENT TO CASH BASIS	A	5719	OTHER ADMINISTRATIVE	5	104
53	WORKERS COMP TO CASH BASIS	A	1612	OTHER ADMINISTRATIVE	5	104
54	STRESS TEST	A	-9491	STRESS TEST	43C	134
55	HOLTER MONITOR	A	-21774	HOLTER MONITOR	43D	135
56	MORD SER RES INTEREST	B	-71251	DEPRECIATION-BUILDING	2	101
57	AMORTIZATION	A	-32497	DEPRECIATION-BUILDING	2	101
57A	MISCELLANEOUS INCOME	B	-6982	OTHER ADMINISTRATIVE	5	104
58	SUBTOTAL	---	$ -1507677			
59	GRANTS, GIFTS, AND INCOME DESIGNATED BY DONOR FOR SPECIFIC EXPENSES (CHAPTER 6)		0			0
60	UTILIZATION REVIEW - PHYSICIANS' COMPENSATION (CHAPTER 21)		0			0
61	DEPRECIATION - BUILDINGS AND FIXTURES	A	67321	DEPRECIATION-BUILDING	2	101
62	DEPRECIATION - MOVABLE EQUIPMENT		0			0
63			0			0
64	TOTAL	---	$ -1440356			

BASIS FOR ADJUSTMENT
A. COSTS--IF COSTS, INCLUDING APPLICABLE OVERHEAD, CAN BE DETERMINED.
B. AMOUNT RECEIVED--IF COST CANNOT BE DETERMINED.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

NO: C-1-83-622

BETHESDA HOSPITAL, ET AL., PLAINTIFFS,

v.

MARGARET M. HECKLER,
SECRETARY OF HEALTH
& HUMAN SERVICES, DEFENDANT.

(Filed Nov. 25, 1985)

ORDER OF REMAND

This matter came on for consideration of plaintiffs' motion for a money judgment in the amount of $2,965,767, plus post-judgment interest, at the statutory rate (doc. 60). Defendant opposes the motion and has filed a motion to remand (doc. 63). Plaintiffs have filed their reply (doc. 64), defendant has filed its supplemental memoranda (docs. 65 and 67), and plaintiffs have filed two notices of new authority (docs. 66 and 68).

Previously, we have entered summary judgments in favor of the plaintiffs (doc. 58) on the question of liability, and we asked the parties to brief the issues of appropriate relief. After examining 42 U.S.C. § 1395(oo), which includes judicial review of the decision of the Provider Reimbursement Review Board and the Secretary and refers to the manner in which judicial review will be accomplished pursuant to Chapter 7 of Title 5 of the United States Code, we conclude that Title 5, U.S.C. § 706 does

not provide for the granting of a judgment as prayed for by plaintiffs. Rather, the reviewing court shall:

1) compel agency action unlawfully withheld or unreasonably delayed; and
2) hold unlawful and set aside agency action, findings, and conclusions found to be–
   (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.

42 U.S.C. § 706.

Therefore, we believe that the appropriate relief for this case is to remand this case to the Secretary of Health & Human Services for further proceedings consistent with this Court's Opinion, including the granting of judgment to plaintiffs in the amount of $2,965,767, plus post-judgment interest at the statutory rate in accordance with the schedule attached to plaintiffs' motion and incorporated by reference herein. The schedule lists the amounts previously determined by the Provider Reimbursement Review Board to be due to each listed hospital for all cost reporting years under appeal and which lists the pre-judgment interest due through April 30, 1985 in accordance with 42 U.S.C. § 1395(oo)(f)(2).

We specifically decline to remand this case to the Secretary for retroactive rule making or to stay this case pending completion of the rule making initiated by the Secretary on June 17, 1985. It is also unnecessary to stay this case, as the Supreme Court of the United States has denied the petitions for certiorari of the Secretary in *Heckler v. Abington Memorial Hospital,* No. 85-52 and *Heckler v. Humana of Aurora, Inc., dba Aurora Community Hospitals,* No. 85-53 (*see* 54 U.S.L.W. 3227, October 7, 1985).

SO ORDERED.

/s/ S. ARTHUR SPIEGEL

S. Arthur Spiegel
United States District Judge

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

No: C-1-83-622
(Spiegel, J.)

BETHESDA HOSPITAL, ET AL., PLAINTIFFS,

v.

OTIS R. BOWEN, M.D.,
SECRETARY OF HEALTH
and HUMAN SERVICES, DEFENDANT.

(Filed Feb. 20, 1986)

AMENDMENT TO ORDER ENTERED NOVEMBER 25, 1985

Having considered defendant's motion to amend judgment, plaintiffs' response, and the full record herein, it is this 19th day of February, 1986, hereby

ORDERED that defendant's motion to amend judgment be, and it hereby is, granted in part, and

IT IS FURTHER ORDERED that the next to last full paragraph of the court's Order dated November 15, 1985, be amended as follows:

> Therefore, we believe that the appropriate relief for this case is to remand this case to the Secretary of Health and Human Services and that defendant shall pay plaintiffs, for all cost reporting periods under appeal, its costs of malpractice insurance under the prior valid regulation, 42 CFR § 405.452(a)(1)(i)(1983) without reference to the invalidated exception in 42 CFR § 405.452(a)(1)(ii), plus interested

> computed to the date of payment, in accordance with 42 U.S.C. § 1395oo(f)(2). Such calculation and payment is to be accomplished within 60 days.

IT IS FURTHER ORDERED that the following paragraph be added to the end of the court's order dated November 25, 1985:

> Having determined that this court is without jurisdiction to rule on the merits of the claims of Bethesda Hospital and Deaconess Hospital until those claims are reviewed on their merits by the Provider Reimbursement Review Board, or until the Board decides that it is without jurisdiction to review those claims on their merits because they involve a challenge to a Medicare regulation, the claims of Bethesda Hospital and Deaconess Hospital are hereby remanded to the Board for action within thirty days of this order: either an order granting expedited judicial review or a decision upon its review of the merits of the remanded claims.

/s/ SPIEGEL, J.
United States District Judge

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Title omitted in printing.

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80
APPORTIONMENT OF MALPRACTICE INSURANCE COSTS
SUBMITTED IN LIEU OF HCFA-2552, PAGE 27
HOSPITAL

RUN DATE: 04/20/81

WORKSHEET D-8

PART I - PAID MALPRACTICE LOSSES

		TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5
		0	7261	0	2498	9759
1 CURRENT PERIOD LOSSES						
2 PRIOR PERIOD LOSSES:		0	0	0	0	0
COST REPORTING PERIOD ENDED:	1979	0	0	0	0	0
3	1978	0	0	0	158	158
4	1977	0	0	0	734	734
5	1976	0	7261	0	3390	10651
6 TOTAL						

PART II - APPORTIONMENT TO HEALTH CARE PROGRAMS

7 IF THERE ARE NO ENTRIES ON LINES 1 THROUGH 6, ENTER THE NATIONAL RATIO FOR:

A. TITLE V 0.000000 B. TITLE XVIII 0.000000 C. TITLE XIX 0.000000

IF LINE 7 IS COMPLETED, DO NOT COMPLETE LINES 8, 9 AND 10.

8 RATIO OF TITLE V MALPRACTICE LOSSES TO TOTAL	0.00000000
9 RATIO OF TITLE XVIII MALPRACTICE LOSSES TO TOTAL	0.68172003
10 RATIO OF TITLE XIX MALPRACTICE LOSSES TO TOTAL	0.00000000
11 CURRENT PERIOD MALPRACTICE INSURANCE PREMIUMS OR FUND CONTRIBUTIONS	377217
12 HOME HEALTH AGENCY MALPRACTICE INSURANCE PREMIUMS AND/OR FUND CONTRIBUTIONS	
FROM WKST C, COL 10, HCFA LINE 34A $ 0 / FROM WKST B, COL 21, HCFA LINE 74 $ 18101206 = 0.00000000 X LINE 11	- 0
13 NET MALPRACTICE INSURANCE PREMIUMS AND/OR CONTRIBUTIONS	377217
14 TOTAL TITLE V MALPRACTICE INSURANCE COSTS	0
15 TOTAL TITLE XVIII MALPRACTICE INSURANCE COSTS	257156
16 TOTAL TITLE XIX MALPRACTICE INSURANCE COSTS	0

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80 RUN DATE: 04/20/81
APPORTIONMENT OF MALPRACTICE INSURANCE COSTS
SUBMITTED IN LIEU OF HCFA-2552- PAGE 27 (CONT'D) WORKSHEET D-3
HOSPITAL

DESCRIPTION	HEALTH CARE PROGRAM CHARGES 1	RATIO 2	COST 3
17 TITLE V			
A HOSPITAL	0	0.00000000	0
B SUBPROVIDER I	0	0.00000000	0
C SUBPROVIDER II	0	0.00000000	0
D TOTAL TITLE V CHARGES	0	0.00000000	0
18 TITLE XVIII			
A HOSPITAL - PART A	6709153	0.95661632	246000
B HOSPITAL - PART B	304268	0.04338368	11156
C SUBPROVIDER I - PART A	0	0.00000000	0
D SUBPROVIDER I - PART B	0	0.00000000	0
E SUBPROVIDER II - PART A	0	0.00000000	0
F SUBPROVIDER II - PART B	0	0.00000000	0
G SKILLED NURSING FACILITY - PART A	0	0.00000000	0
H SKILLED NURSING FACILITY - PART B	0	0.00000000	0
I TOTAL TITLE XVIII CHARGES	7013421	1.00000000	257156
19 TITLE XIX			
A HOSPITAL	0	0.00000000	0
B SUBPROVIDER I	0	0.00000000	0
C SUBPROVIDER II	0	0.00000000	0
D TOTAL TITLE XIX CHARGES	0	0.00000000	0

PART III - DIRECTLY ASSIGNED MALPRACTICE COSTS--TITLE V AND TITLE XIX

	TITLE V 1	TITLE XIX 2
20 HOSPITAL	0	0
21 SUBPROVIDER I	0	0
22 SUBPROVIDER II	0	0

PART IV - DIRECTLY ASSIGNED MALPRACTICE COSTS--TITLE XVIII

	PART A 1	PART B 2
23 HOSPITAL	0	0
24 SUBPROVIDER I	0	0
25 SUBPROVIDER II	0	0
26 SKILLED NURSING FACILITY	0	0

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Title omitted in printing.

[illegible] MEDICARE POSTPAR SYSTEM
[illegible] HOSPITAL PROV NO 36-0039 FROM 01/01/80 TO 12/31/80 RUN DATE: 04/16/81
[illegible] OF MALPRACTICE INSURANCE COSTS
SUBMITTED IN LIEU OF HCFA-2552, PAGE 27 WORKSHEET D-8
HOSPITAL

PART I - PAID MALPRACTICE LOSSES

		TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5
1	CURRENT PERIOD LOSSES	0	0	0	0	0
2	PRIOR PERIOD LOSSES:					
	COST REPORTING PERIOD ENDED: 1979	0	0	0	3500	3500
3	1978	0	12900	0	29965	41965
4	19	0	0	0	0	0
5	19	0	0	0	0	0
6	TOTAL	0	12900	0	33465	45465

PART II - APPORTIONMENT TO HEALTH CARE PROGRAMS

IF YOU ARE NO ENTRIES ON LINES 1 THROUGH 6, ENTER THE NATIONAL RATIO FOR:

A. TITLE V 0.000000 B. TITLE XVIII 0.000000 C. TITLE XIX 0.000000

IF LINE 7 IS COMPLETED, DO NOT COMPLETE LINES 8, 9 AND 10.

8	RATIO OF TITLE V MALPRACTICE LOSSES TO TOTAL	0.00000000
9	RATIO OF TITLE XVIII MALPRACTICE LOSSES TO TOTAL	0.24393729
10	RATIO OF TITLE XIX MALPRACTICE LOSSES TO TOTAL	0.00000000
11	CURRENT PERIOD MALPRACTICE INSURANCE PREMIUMS OR FUND CONTRIBUTIONS	243306
12	OTHER HEALTH AGENCY MALPRACTICE INSURANCE PREMIUMS AND/OR FUND CONTRIBUTIONS	
	FROM WKST C, COL 10, HCFA LINE 348 $ 0 0.00000000 * LINE 11 =	0
	FROM WKST B, COL 21, HCFA LINE 74 $ 21877603	
13	NET MALPRACTICE INSURANCE PREMIUMS AND/OR CONTRIBUTIONS	243306
14	TOTAL TITLE V MALPRACTICE INSURANCE COSTS	0
15	TOTAL TITLE XVIII MALPRACTICE INSURANCE COSTS	64219
16	TOTAL TITLE XIX MALPRACTICE INSURANCE COSTS	0

BEST AVAILABLE COPY

FROST & [illegible]
OPACOMP [illegible] HOSPITAL PMRW #1 34-0039 FOR: 01/01/80 TO 12/31/80 RUN DATE: 04/16/81
APPORTIONMENT OF MALPRACTICE INSURANCE COSTS
SUBMITTED IN LIEU OF HCFA-2552a PAGE 27 (COMPUTED) WORKSHEET D-8
HOSPITAL

DESCRIPTION	HEALTH CARE PROGRAM CHARGES 1	RATIO 2	COST 3
17 TITLE V			
A HOSPITAL	0	0.00000000	0
B SUBPROVIDER I	0	0.00000000	0
C SUBPROVIDER II	0	0.00000000	0
D TOTAL TITLE V CHARGES	0	0.00000000	0
18 TITLE XVIII			
A HOSPITAL - PART A	10971432	0.97163747	62397
B HOSPITAL - PART B	320261	0.02836253	1821
C SUBPROVIDER I - PART A	0	0.00000000	0
D SUBPROVIDER I - PART B	0	0.00000000	0
E SUBPROVIDER II - PART A	0	0.00000000	0
F SUBPROVIDER II - PART B	0	0.00000000	0
G SKILLED NURSING FACILITY - PART A	0	0.00000000	0
H SKILLED NURSING FACILITY - PART B	0	0.00000000	0
I TOTAL TITLE XVIII CHARGES	11291693	1.00000000	64218
19 TITLE XIX			
A HOSPITAL	0	0.00000000	0
B SUBPROVIDER I	0	0.00000000	0
C SUBPROVIDER II	0	0.00000000	0
D TOTAL TITLE XIX CHARGES	0	0.00000000	0

PART III - DIRECTLY ASSIGNED MALPRACTICE COSTS--TITLE V AND TITLE XIX	TITLE V 1	TITLE XIX 2
20 HOSPITAL	0	0
21 SUBPROVIDER I	0	0
22 SUBPROVIDER II	0	0

PART IV - DIRECTLY ASSIGNED MALPRACTICE COSTS--TITLE XVIII	PART A 1	PART B 2
23 HOSPITAL	0	0
24 SUBPROVIDER I	0	0
25 SUBPROVIDER II	0	0
26 SKILLED NURSING FACILITY	0	0

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 86-3090

BETHESDA HOSPITAL, ET AL., PLAINTIFFS-APPELLEES,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,
DEFENDANT-APPELLANT.

(Filed Feb. 2, 1987)

Before: KEITH and GUY, Circuit Judges; and EDGAR, District Judge.

JUDGMENT

ON APPEAL from the United States District Court for the Southern District of Ohio.

THIS CAUSE came on to be heard on the record from the said district court and was argued by counsel.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this court that the judgment of the said district court in this case be and the same is hereby affirmed in part and reversed in part, and the case is remanded in accordance with this opinion.

Each party is to bear its own costs on appeal.

ENTERED BY ORDER OF THE COURT
John P. Hehman, Clerk

/s/ JOHN P. HEHMAN
Clerk

A True Copy.
Attest:

/s/ GARY MCCARTHY
Deputy Clerk

Title omitted in printing.
Exhibit B to Petition for Rehearing En Banc

(EXCERPT FROM TRANSCRIPT OF PRRB HEARING)

PEACHFORD HOSPITAL (ATLANTA, GEORGIA)

v.

MUTUAL OF OMAHA INSURANCE COMPANY.

PRRB HEARING DEC. No. 84-D122, MAY 15, 1984
(Cost Reporting Period ending Dec. 31, 1981).

---

* * *

MS. KRAUS: The Board has some questions for you. Thank you. Mr. Dudgeon?

EXAMINATION BY MR. DUDGEON:

Q The only thing I'd like to clear up is as to the nature of the dispute. The issue is stated as whether scholastic training costs are allowable costs under the Medicare program. Yet, I gather from reading, that somewhere here that the adjustment made by the Intermediary was only to allocate indirect costs to educational costs that the Provider had already itself disallowed.

What is really in dispute here? What was the adjustment?

A The adjustment made by the Intermediary was the indirect cost. You are correct in that Provider did, when filing the cost report, remove the direct costs. Those direct costs however include not only what we will show later is the direct education portion which is integrated with the therapy portion and what we're trying to say to you and to the Board is that in fact that is an error, an error that the Provider made and then it was compounded again by the Intermediary allocating indirect costs.

Q Did you request that the Intermediary re-open and ask that these costs be allowed, the $102,000 direct cost?

A I'm not sure, to be honest with you, sir. I know we have been in discussion with them concerning this issue.

MR. DUDGEON: We may or may not have a jurisdictional problem here. Ms. Kraus will worry about that during the break and check with our legal officer on it, I gather. I don't have any more questions of this witness.

* * *

WITNESS: Madam Chairman, if I might, I've been given a letter that we wrote to Mutual of Omaha, May 27, 1982 in which we asked that the reconsider the adjustment disallowing school costs. And that was in total, not only our original offset but also the overhead cost that was allocated.

MS. KRAUS: Mr. Hamaker, before we proceed any further and before I seek legal advice, can you tell me exactly what you think is in dispute, what the adjustment was so we can have the jurisdictional matter squared away. I'm a little bit concerned that we do have a problem here in terms of what's in dispute.

MR. HAMAKER: Yes, I think I can. The Provider has removed, did remove, approximately $103,000 of direct costs for this scholastic training expense. The Intermediary then set this, actually restated this by setting it up as a non-reimbursable cost center so that it would receive a share of overhead costs. And I believe that the share of overhead costs amounted to approximately $55,000.

MS. KRAUS: They removed the $103,000 entirely from the cost report? It was not claimed? I don't quite understand.

MR. HAMAKER: The Provider removed that on their filed cost report. So they considered that as not an allowable cost.

MS. KRAUS: That's all the questions I have. I do have a few question of the witness.

EXAMINATION BY MS. KRAUS:

Q You said that this is not just an educational program.

A Yes, ma'am.

Q Now I don't know what you mean by that.

A I think that we will show from the witnesses here that it is an integral part of the treatment process at Peachford Hospital. That is to say that we're not just in there teaching them math, science, etc. But by the structure of the classroom and by the interplay of the teachers with students we will clearly demonstrate this today.

Q You said that the teachers were also therapists.

A That's what I was trying to say earlier.

Q You don't know.

A I don't know.

Q Was this denial of payment a written denial?

A I'm not sure.

Q You don't know.

A I don't think so. I believe it was more oral. We would go to the board and say will you pay and they'll say no we don't pay for institutionalized patients.

Q Thank you.

MS. KRAUS: Thank you very much. Before we proceed, because of this jurisdictional matter, I would like to get clarified, I would like to take a ten minute break.

(BRIEF RECESS)

MS. KRAUS: Ladies and gentlemen, I just would like the record to be clear so there is no question regarding jurisdiction, as I understand it the Provider removed the $103,000 on their filed cost report, basically self disallowing those costs. The Intermediary reinstated those costs as a non-reimbursable cost center in order to pick up its share of indirect.

In view of the fact that the cost report is before this Board, the dispute regarding both directs and indirects will

be heard and the amount in controversy will be the $103,000 plus the $55,000 of indirect. And the basis for the Board accepting that amount as the amount in controversy is provided for under 405.1869 which states that when a cost report is before the Board the Board may exercise jurisdiction over any matter.

This is an unusual case and therefore that is the ruling of this Board.

* * *

Supreme Court, U.S.
FILED
NOV 19 1987
JOSEPH F. SPANIOL, JR.
CLERK

No. 86-1764

In the Supreme Court of the United States

OCTOBER TERM, 1987

BETHESDA HOSPITAL ASSOCIATION AND
THE DEACONESS HOSPITAL OF CINCINNATI, OHIO,
PETITIONERS,

v.

OTIS R. BOWEN, M.D., SECRETARY
OF HEALTH AND HUMAN SERVICES,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF FOR THE PETITIONERS

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QUESTIONS PRESENTED FOR REVIEW

1. Where a Medicare regulation prohibits certain reimbursement and the fiscal intermediary has no authority to deviate from the regulation, can the Provider Reimbursement Review Board refuse to exercise jurisdiction over a provider's appeal to challenge the regulation on the ground that the provider complied with the regulation when completing the Medicare cost report it filed with the intermediary?

2. Even if the Secretary has authority to require a provider to dispute a regulation when filing its cost report, can the Secretary implement such a requirement without notice to the provider?

LIST OF PARTIES AND RULE 28.1 LIST

The parties to the proceedings below were the petitioners Bethesda Hospital Association and The Deaconess Hospital of Cincinnati, Ohio, and the Respondent Otis R. Bowen, M.D., Secretary of Health and Human Services.

The following Ohio hospitals were also plaintiffs-appellees in the proceedings below: Bethesda Hospitals, Inc. of Cincinnati; Brown County General Hospital; Clinton Memorial Hospital; Doctors Hospital, Inc.; Doctors Hospital of Nelsonville; Good Samaritan Medical Center; Grady Memorial Hospital; Guernsey Memorial Hospital; Kettering Medical Center; Lancaster-Fairfield Community Hospital; Madison County Hospital, Inc.; East Ohio Regional Hospital, Inc. d/b/a Martins Ferry Hospital; Medical Center Hospital; Memorial Hospital of Union County; The Mercy Hospital Corporation; Mercy Memorial Hospital of Urbana, Ohio, Inc.; Miami Valley Hospital; Ohio State University Hospitals; Our Lady of Mercy Hospital of Mariemont; Pike Health Services, Inc., d/b/a Pike Community Hospital; Riverside United Methodist Hospital; St. Ann's Hospital of Columbus, Inc.; St. John Medical Center; Sycamore Medical Center; and Shelby County Memorial Hospital Association, d/b/a Wilson Memorial Hospital. Because these hospitals are not affected by the jurisdictional issue presented for review, they are not named as parties herein.

The parent company of petitioner Bethesda Hospital Association is Care One Health Systems, Zanesville, Ohio.

The parent company of petitioner The Deaconess Hospital of Cincinnati, Ohio is The Deaconess Associates, Inc., Cincinnati, Ohio.

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In the Supreme Court of the United States

OCTOBER TERM, 1987

No. 86-1764

BETHESDA HOSPITAL ASSOCIATION AND
THE DEACONESS HOSPITAL OF CINCINNATI, OHIO,
PETITIONERS,

v.

OTIS R. BOWEN, M.D., SECRETARY
OF HEALTH AND HUMAN SERVICES,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE PETITIONERS

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-8a) is reported at 810 F.2d 558. The opinion of the district court (Pet. App. 29a-51a) is reported at 609 F. Supp. 1360. The decision of the Provider Reimbursement Review Board (Pet. App. 52a-58a) is not reported.

JURISDICTION

The judgment of the court of appeals was issued and entered on February 2, 1987. The judgment was amended by an order entered February 25, 1987. Pet. App. 9a. The petition for rehearing en banc was filed February 17, 1987, and was denied by order dated July 1, 1987. Jt. App. 68a.

The petition for a writ of certiorari was filed on May 2, 1987, and was granted on October 5, 1987. The jurisdiction of this Court rests upon 28 U.S.C. § 1254(1) (1982).

STATUTES INVOLVED

This case involves the statute creating the Provider Reimbursement Review Board, 42 U.S.C. § 1395oo (1982). The statute is reprinted in the appendix.

STATEMENT OF THE CASE

Introduction

This case arises in the context of a hospital industry-wide challenge to the Secretary's regulatory change in the way the Medicare program reimburses hospitals for their costs of malpractice insurance. The courts have resoundingly rejected the merits of this change in reimbursement methodology. As a result, the Secretary has had to pay millions of dollars, including substantial interest payments, to provider hospitals to remedy the Medicare reimbursement they lost under the attempted change.

The Secretary, however, refuses to pay the hospital petitioners, contending that because they complied with the now-discredited regulation in completing their Medicare cost reports, they cannot be permitted to enter the administrative and judicial review process to challenge the regulation. This position denies the hospitals access to the only forum in which they can press their claim that they were underpaid, and takes advantage of a natural inclination to follow instructions in completing complicated filings. Such a position is not supported by the Medicare statute.

Medicare Reimbursement Scheme

During the 1980 cost year here at issue,[1] hosp'tals certified to participate in the Medicare program established

[1] For cost years beginning on or after October 1, 1983, most hospitals became subject to the Medicare prospective payment system (PPS). Under PPS, hospitals are paid a predetermined amount for each discharge, which varies according to the diagnosis of the patient. 42 U.S.C. § 1395ww(d) (1982). Certain costs for PPS hospitals (outpatient, capital, medical education), as well as hospitals exempt from PPS (children's hospitals, psychiatric and rehabilitation hospitals), skilled nursing facilities and home health agencies, are still subject to reasonable cost reimbursement.

by Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ww (1982), generally were reimbursed the "reasonable cost" of providing services to Medicare patients. 42 U.S.C. §§ 1395f(b) (1982), 1395x(v)(1)(A) (1982)[2]. The petitioners, Bethesda Hospital and Deaconess Hospital (hereinafter "Hospitals") are providers of inpatient hospital services to Medicare beneficiaries, pursuant to a provider agreement with the Secretary of Health and Human Services ("Secretary"). This case arises from the attempt of the Hospitals first to challenge the Secretary's 1979 regulation, 42 C.F.R. § 405.452(b)(1)(ii)(1979) ("the 1979 Malpractice Rule"), and then to challenge the retroactive application of 42 C.F.R. § 413.56 (1986) ("the 1986 Malpractice Rule") which the Secretary adopted after the 1979 Malpractice Rule and had been invalidated.

The 1979 Malpractice Rule radically altered the utilization method used by the Medicare program since its inception in 1966 to apportion malpractice insurance costs between Medicare and non-Medicare patients for reimbursement purposes.[3] The two Hospitals were first subject

[2] Section 1395f(b) . quires the Secretary to pay a hospital the lesser of the "reasonable cost" of its services or its customary charge. Only in unusual circumstances are a hospital's customary charges less than its reasonable cost.

[3] Under the utilization method, malpractice premium costs were aggregated with other indirect costs, such as business office costs. After interim allocations, all these indirect costs were allocated to revenue producing cost centers in the hospital, based upon the ratio of accumulated costs of such cost centers. Once allocated, the malpractice and other indirect costs would be apportioned between Medicare and

to the 1979 Malpractice Rule for their fiscal year beginning January 1, 1980 and ending December 31, 1980.

After the close of the year, the Hospitals submitted to their fiscal intermediary[4] a Medicare cost report, in the form mandated by the Secretary. The cost report includes every cost incurred by a hospital for each and every activity in which it engages—whether or not the activity represents a reimbursable activity or, for that matter, a patient care activity. These costs are entered upon various schedules and worksheets in the cost report which serve to allocate costs to the various reimbursable and non-reimbursable cost centers and then, for the reimbursable cost centers, to apportion the costs between Medicare and non-Medicare patients. By completing the component schedules of the cost report according to the Secretary's instructions and regulations, the hospital calculates its Medicare reimbursement. The submission of a cost report is not an adversary proceeding but merely triggers an accounting audit.

---

non-Medicare patients for each such cost center based upon usage, i.e. if a hospital had an intensive care unit as a cost center and 41% of the patient days were Medicare patient days, Medicare would reimburse the hospital 41% of the malpractice premium and other indirect costs that had been allocated to the intensive care unit.

Under the 1979 Malpractice Rule, malpractice premium costs were removed from the pool of indirect costs and apportioned based upon actual claims history. Thus, a hospital with a $100,000 malpractice insurance premium might receive payment ranging from nothing to 100% of its cost, depending upon whether it had any malpractice loss experience and, if so, whether there were any Medicare patients involved.

[4] A fiscal intermediary is a private organization, usually an insurance company, that contracts with the Secretary to perform Medicare payment and audit activities and other selected functions on the Secretary's behalf. 42 U.S.C. § 1395h (1982). Heckler v. Community Health Services of Crawford County, 467 U.S. 51, 54 (1984).

The intermediary audits the cost report in accordance with the Secretary's regulations and policies. If the intermediary disallows, reallocates, or reapportions all or part of any category of costs, it prepares an audit adjustment report listing such disallowances and related adjustments. The intermediary then issues its determination of the reimbursement due the hospital for services rendered to Medicare beneficiaries, called a Notice of Program Reimbursement ("NPR"). The NPR and the audit adjustment report that accompanies the NPR explain any revisions made to the calculations in the cost report by the intermediary during the audit to bring it into conformity with regulations, and reconciles any interim payments the hospital may have received during the year with the total amount payable. 42 C.F.R. § 405.1803 (1986).

When the Hospitals filed their cost reports for FY 1980, they complied with the 1979 Malpractice Rule by completing Worksheet D-8 to the Medicare cost report, "Apportionment of Malpractice Insurance Costs." Jt. App. 58a-61a. Worksheet D-8 required hospitals to list their total malpractice insurance costs on line 11, and then to apply the methodology of the 1979 malpractice regulation in apportioning those costs to the Medicare program. The Hospitals' cost reports thus did include a claim for reimbursement for malpractice insurance costs, but completion of Worksheet D-8 effectuated a "self-disallowance" of those malpractice insurance costs in excess of those allowed under the apportionment methodology of the 1979 Rule. Because these Hospitals complied with the Secretary's regulation and cost report instructions, there was no need for the fiscal intermediary reviewing their cost reports to make an audit adjustment with respect to malpractice insurance costs before it issued an NPR.

Medicare Appeals Scheme

The Medicare statute provides for administrative and judicial review of the NPR. 42 U.S.C. §§ 1395oo(a), (f) (1982). The first stage of the review process is an appeal to the Provider Reimbursement Review Board (hereinafter "PRRB" or "Board"). A hospital must meet the jurisdiction requirements of 42 U.S.C. § 1395oo(a) in order to obtain administrative review by the PRRB of the amount of reimbursement contained in the NPR. Section 1395oo(a) provides:

> Any provider of services which has *filed a required cost report within the time specified in regulations* may obtain a *hearing with respect to such cost report* by a Provider Reimbursement Review Board . . ., *if* (1) such provider – –
>
> (A)(i) *is dissatisfied with a final determination* of the organization serving as its fiscal intermediary pursuant to section 1395h of this title *as to the amount of total program reimbursement* due the provider for the items and services furnished to individuals for which payment may be made under this sub-chapter for the period covered by such report, . . .
>
> • • •
>
> (2) the amount in controversy is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i). . . .

(emphasis added).

Once the jurisdictional requirements of subsection (a) are met and the Board has jurisdiction to hear an appeal, the powers and scope of review of the PRRB are discussed in section 1395oo(d) (1982):

> A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report *and to make any other revisions on matters covered by such cost report* (including revisions adverse to the provider of services) *even though such matters were not considered by the intermediary in making such final determination.*

(emphasis added).

Judicial review of decisions by the Board is specifically provided in 42 U.S.C. § 1395oo(f).

Course of Proceedings Below

Upon receiving their NPRs, the two Hospitals joined with a group of Ohio hospitals and filed requests for a hearing before the PRRB, seeking reimbursement for malpractice insurance costs under the pre-1979 utilization methodology and challenging the 1979 Malpractice Rule. With respect to all the other providers in the group appeal, the Board found it had jurisdiction over the appeal, and permitted those providers to file their challenge to the 1979 Malpractice Rule directly in federal district court under the expedited judicial review provisions of section 1395oo(f)(1) (1982).[5]

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[5] The Board is bound by the Secretary's regulations. 42 C.F.R. § 405.1867 (1986). As discussed at pages 22 and 30, below, the third through sixth sentences of section 1395oo(f)(1) provide that where a provider seeks to challenge the validity of a regulation by which the Board is bound, the Board can issue a determination that it cannot decide the issue in the case. The provider thereupon can proceed directly to federal district court to challenge the regulation.

However, the Board denied jurisdiction over the Hospitals' appeal, contending that in order to appeal to the Board the Hospitals had to complete Worksheet D-8 incorrectly so as to apportion malpractice premium costs to Medicare in excess of the amounts allowed by the 1979 Malpractice Rule, or otherwise state its claim. Thereupon, the intermediary could make an audit adjustment to reapportion the Hospitals' malpractice premium costs in accordance with the 1979 Malpractice Rule and thereby disallow the costs above those permitted by the 1979 Malpractice Rule. Pet. App. 54a. The Board decided that this was required to meet the statutory requirement of section 1395oo(a)(1)(A)(i) (1982) that a provider be "dissatisfied with a final determination" of the intermediary. *Id.*

All the providers (including the two Hospitals) appealed to federal district court, pursuant to 42 U.S.C. § 1395oo(f)(1). The district court subsequently invalidated the 1979 Malpractice Rule (Pet. App. 42a-51a), as did the Sixth Circuit in another case, *Cumberland Medical Center v. Secretary of Health and Human Services,* 781 F.2d 536 (6th Cir. 1986).[6] The Secretary appealed the district court decision and, during the pendency of the appeal, adopted

[6] While not a single appellate court has upheld the 1979 Malpractice Rule, numerous courts have invalidated it. *See, e.g.,* Bedford County Memorial Hospital v. Health and Human Services, 769 F.2d 1017 (4th Cir. 1985); Menorah Medical Center v. Heckler, 768 F.2d 292 (8th Cir. 1985); DeSoto General Hospital v. Heckler, 766 F.2d 182 (5th Cir. 1985); Lloyd Noland Hospital and Clinic v. Heckler, 762 F.2d 1561 (11th Cir. 1985); St. James Hospital v. Heckler, 760 F.2d 1460 (7th Cir.), *cert. denied,* 474 U.S. 902 (1985); Humana of Aurora, Inc. v. Heckler, 753 F.2d 1579 (10th Cir.), *cert. denied,* 476 U.S. 863 (1985); Abington Memorial Hospital v. Heckler, 750 F.2d 242 (3d Cir. 1984), *cert. denied,* 474 U.S. 863 (1985); Walter O. Boswell Memorial Hospital v. Heckler, 628 F. Supp. 1121 (D.D.C. 1985).

the revised 1986 Malpractice Rule, with retroactive effect to July 1, 1979. The Sixth Circuit, following its earlier decision in *Mason General Hospital v. Secretary of the Department of Health and Human Services,* 809 F.2d 1220 (6th Cir. 1987), ruled in favor of the 25 other hospitals in the group appeal and invalidated retroactive application of the 1986 Malpractice Rule.[7] Pet. App. 4a.

With respect to the two Hospitals, the district court reversed the decision of the Board denying jurisdiction over their appeals. The court found that the plain language of section 1395oo(d), which authorizes the Board "to make any other revisions on matters covered by [the] cost report . . . even though such matters were not considered by the intermediary in making such final determination," gives the Board jurisdiction to hear self-disallowed claims, despite the fact the intermediary did not first deny such claims. Pet. App. 34a-35a. The district court also held that the doctrine of exhaustion of administrative remedies does not support the Secretary's position that claims must first be presented to the intermediary, because the intermediary is bound by the Secretary's regulations and therefore cannot grant the relief the petitioners seek, i.e., invalidation of the 1979 Malpractice Rule. Pet. App. 40a-41a.

[7] To date three courts of appeals have invalidated the 1986 Malpractice Rule insofar as it is retroactively applied to prior years. Mason General Hospital v. Secretary of the Department of Health and Human Services, 809 F.2d 1220 (6th Cir. 1987); Tallahassee Memorial Regional Medical Center v. Bowen, 815 F.2d 1435 (11th Cir. 1987), *cert. pending,* No. 87-830; St. Peter's Medical Center v. Bowen, No. 86-5371 (3d Cir., February 23, 1987). The Seventh Circuit, while not ruling on the merits or retroactivity of the 1986 Rule, remanded the case to the Secretary for application of the 1986 Rule. Appleton Memorial Hospital v. Bowen, 814 F.2d 408 (7th Cir. 1987).

The Sixth Circuit reversed the decision of the district court on the self-disallowance issue because it was bound by the previous decision of another panel of the Sixth Circuit in *Baptist Hospital East v. Secretary of Health and Human Services,* 802 F.2d 860 (6th Cir. 1986). Pet. App. 10a-28a. The panel in *Baptist Hospital East* found that where a provider complies with the Secretary's regulation in completing its cost report and effects a self-disallowance, it has disclaimed entitlement to reimbursement for costs in excess of those allowed under the regulations. Pet. App. 14a. The *Baptist Hospital East* panel adopted the analysis of the Court of Appeals for the D.C. Circuit in *Athens Community Hospital, Inc. v. Schweiker,* 743 F.2d 1 (D.C. Cir. 1984) (*Athens II*), *modifying* 686 F.2d 989 (1982) (*Athens I*). *Athens II* held that in order for the Board to have jurisdiction over a provider's appeal, a provider must present a claim for reimbursement by completing the cost report in a manner that will force an intermediary disallowance or otherwise notify the intermediary of its dispute before the intermediary issues the NPR.[8]

The result of the Sixth Circuit decision is that the Hospitals are thus reimbursed for their malpractice insurance costs according to the methodology of the 1986

[8] The earliest appellate decision on the self-disallowance issue was that of the Seventh Circuit in St. Mary of Nazareth Hospital Center v. Department of Health and Human Services, 698 F.2d 1337 (7th Cir.), *cert. denied,* 464 U.S. 830 (1983), which held that the PRRB has jurisdiction over self-disallowance. The Fourth Circuit and the Eleventh Circuit followed the *Athens* decision, and held against the hospitals. Community Hospital of Roanoke Valley v. Health and Human Services, 770 F.2d 1257 (4th Cir. 1985); North Broward Hospital District v. Bowen, 808 F.2d 1405 (11th Cir. 1987), *cert. pending,* No. 86-1986.

Most recently, the Ninth and Eleventh Circuits have rejected the *Athens* rationale and concluded that the Board must hear appeals of

Malpractice Rule,[9] despite the fact the Sixth Circuit has held that the 1986 Rule cannot be retroactively applied to these cost years.

SUMMARY OF ARGUMENT

The Secretary's policy of denying administrative and judicial review to providers that self-disallow costs by following the Secretary's regulations is inconsistent with the plain language and intent of section 1395oo and therefore is invalid. The statute sets forth only four requirements to permit a provider to appeal to the Board. A provider must (1) file a cost report; (2) be dissatisfied with

self-disallowances. Adams House Health Care v. Heckler, 817 F.2d 587 (9th Cir. 1987), *cert. pending,* No. 87-443; Tallahassee Memorial Regional Medical Center, 815 F.2d 1435 (11th Cir. 1987), *cert. pending,* No. 87-380 (distinguishing *North Broward* on the grounds that *Tallahassee* involved a challenge to a regulation while *North Broward* did not, thereby invoking a different authority for judicial review). The First Circuit has also rejected *Athens,* but concluded that the Board has discretionary authority to hear appeals of self-disallowances. St. Luke's Hospital v. Secretary of Health and Human Services, 810 F.2d 325 (1st Cir. 1987).

[9] Following publication of the 1986 Malpractice Rule, the Hospitals received a supplemental payment which increased their reimbursement over what they would have received under the 1979 Malpractice Rule, but which still reimbursed them substantially less than they would have received under the utilization methodology. The Secretary has indicated that the 1986 Malpractice Rule will not be retroactively applied to hospitals that self-disallowed under the 1979 Malpractice Rule. *Tallahassee,* 815 F.2d at 1449 n.26. Thus there is a possibility that the Secretary will seek to recoup the payments made to the Hospitals under the 1986 Malpractice Rule, leaving the Hospitals reimbursed under the totally repudiated methodology of the 1979 Malpractice Rule.

its total amount of reimbursement; (3) have the requisite amount in controversy; and (4) timely file an appeal. The Secretary contends that the Hospitals did not have the requisite dissatisfaction because they did not dispute the 1979 Malpractice Rule with the intermediary when they filed their cost reports so that the intermediary could disallow those costs not allowed by the regulation. There is nothing in the language of the statute to support the Secretary's interpretation that a provider can appeal only what the intermediary has expressly disallowed.

Alternatively, even if the Court finds the Secretary's interpretation to be a plausible reading of the statute, there are no practical considerations to support that interpretation and thus it is not entitled to deference. To require a provider to violate a regulation or manual provision when completing its cost report merely so that the intermediary can make an audit adjustment, when the intermediary is bound by the regulations and manual provisions and can provide no relief, is a wasteful exercise that accomplishes nothing. So long as costs are included in the cost reporting process, the Secretary's interests in the orderly administration of the Medicare program are not jeopardized by a reading of the statute that permits providers to appeal their challenges to regulations and manual provisions to the PRRB, whether or not a provider complied with those provisions in completing the cost report. Because malpractice insurance costs are a category of costs included in the normal cost reporting process, there is no danger that the provider can raise stale or frivolous claims.

In addition, a reading of the statute which vests in the Secretary the authority to restrict access to administrative and judicial review, when the statute does not expressly exclude self-disallowing providers from such access, runs afoul of the presumption favoring judicial review and permits a delegation which unduly restricts the waiver of sovereign immunity granted by Congress. Finally, in any

event, the Hospitals cannot be deprived of review when they were given no notice that, by complying with the then-new 1979 Malpractice Rule, they were abandoning their right to challenge that regulation.

The Circuits have split on the question whether the PRRB has jurisdiction over appeals concerning self-disallowed costs. The split arises from the decisions of the D.C. Circuit in *Athens I* and *II*. The *Athens* decisions are wrong because the court confused the section of the statute which delineates the powers of the PRRB once it has jurisdiction over an appeal with the section which delineates the jurisdictional requirements a provider must meet to appeal to the PRRB. The court also misconstrued the practical consequences of the Secretary's interpretation.

ARGUMENT

I. THE SECRETARY'S POLICY OF DENYING ADMINISTRATIVE AND THEREBY JUDICIAL REVIEW IS INCONSISTENT WITH THE PLAIN LANGUAGE OF THE STATUTE.

The starting point for any analysis of a statute is the language of the statute itself. *Consumer Product Safety Commission v. GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980). Two subsections of section 1395oo are relevant here. Subsection (a) sets forth the jurisdictional criteria a provider must meet to be entitled to a hearing at the Board, while subsection (d) sets forth the functions of the Board upon hearing the provider's claim. The Secretary's interpretation that an intermediary audit adjustment is required in order for a provider to appeal to the Board is not supported by the statutory language in either of these provisions.

A. The Hospitals Meet The Statutory Requirement In Section 1395oo(a) That They Be Dissatisfied With The Total Amount Of Reimbursement.

At the outset, it is important to realize that subsection (a), not subsection (d), sets forth the jurisdiction of the

Board in terms of those providers that may appeal to the Board. The reason that the self-disallowance issue has become so confused is that the analysis in *Athens* and in virtually all the other decisions has been based on the fundamental error that subsection (d) rather than (a) is the jurisdictional basis for administrative relief for the aggrieved provider. This is most clearly stated in *Athens II*, where the court states: "The PRRB's jurisdiction – –the crux of the dispute here – –is set out in section 1395oo(d) . . . ." 743 F.2d at 3. Section 1395oo(a) is characterized by the *Athens* court as setting forth the PRRB's functions. *Id.* at 6.

A reading of the statutory subsections makes it readily apparent that the *Athens* court has reversed the thrust of the statutory subsections through its characterization. Section 1395oo(a) clearly establishes the PRRB's jurisdiction when it sets forth: (1) those events upon which the provider may take a claim to the PRRB (i.e., the filing of a cost report and dissatisfaction with the total amount of reimbursement offered by the intermediary); (2) the jurisdictional amount ($10,000); and (3) the time within which the appeal must be filed. Section 1395oo(d), on the other hand, governs the Board's conduct once it has jurisdiction over a provider's appeal, requiring the Board's decision to be based upon the record made at the hearing and supported by substantial evidence. It also authorizes the Board to act with regard to other aspects of the cost report before it, even though those aspects may not have been disputed with or taken into account by the intermediary in making its final determination.

Recognizing, then, that subsection (a) governs the Board's jurisdiction, an analysis of that subsection reveals the Board has jurisdiction under that provision to hear self-disallowed costs if the provider meets four conditions. The only issue in dispute here is whether the Hospitals have met the requirement of being dissatisfied with their total amount of reimbursement.

Subsection (a)(1)(A)(i) provides that a hospital may obtain a hearing if it is "dissatisfied with a final determination of [the intermediary] as to the amount of total reimbursement due the provider." There is no dispute between the parties that the "final determination of the amount of program reimbursement" is the NPR received by the Hospitals from the intermediary. *See* 42 C.F.R. § 405.1801 (1986).

All that the plain language of this subsection requires is that the provider be dissatisfied with the *total* amount of reimbursement offered in the NPR, as determined by the Secretary's regulations. Nothing requires that the dissatisfaction be with respect to a particular intermediary audit adjustment. *Adams House Health Care v. Heckler*, 817 F.2d 587, 592 (9th Cir. 1987), *cert. pending*, No. 87-443 ("Section (a) requires that a provider be dissatisfied with the total amount of reimbursement offered by an intermediary, not with the intermediary's reasoning process with respect to any specific costs.").

Furthermore, it is significant that Congress used the words "*is* dissatisfied with a *final* [intermediary] determination" (emphasis added), rather than words like "has expressed dissatisfaction to the Intermediary before the final determination is issued." The wording thus requires that the provider be dissatisfied at the time it receives its NPR, not beforehand. Moreover, the wording states that the provider must only *be* dissatisfied, not that the provider must have *expressed* that dissatisfaction to the intermediary. The provider subsequently expresses that dissatisfaction by appealing to the PRRB.

With regard to the statutory requirement of "dissatisfaction," *Athens II* concluded:

> We do not think Congress intended to permit a provider to claim dissatisfaction based upon its own failure to request reimbursement of a cost item. If a provider is unhappy with the reimbursement the in-

> termediary allowed in such a case, it is the fault of the provider and not the intermediary. It is simply not plausible to contend that Congress has created a scheme where the provider can claim dissatisfaction and have recourse to an appeal procedure because the intermediary failed to read the provider's mind and anticipate all those things the provider would like to be reimbursed for, even though it did not request them.

743 F.2d at 6 (footnote omitted). Here the *Athens* court drew an implausible inference as to Congressional intent that is adverse to the provider's right to be heard without any basis in the language of the statute or its legislative history. Simply put, Congress stated that a provider can appeal when dissatisfied with the determination of the amount of total reimbursement. It is not plausible that Congress intended that the provider should be required to refuse to follow regulations and instructions in completing a cost report, to the great inconvenience of the intermediary, in order to have a right to be heard to challenge a manual instruction or regulation which the intermediary is bound to follow in any event. A provider can hardly be said to be at fault or neglectful when it was following the Secretary's regulations and, as discussed below, when it would have been pointless to dispute the regulation with the intermediary. *Adams House*, 817 F.2d at 592.

The jurisdictional determinant under subsection (a) is the *provider's* dissatisfaction with the total reimbursement due following submission of the cost report, not the *Board's* ability to make revisions to such matters. The Hospitals in this case were dissatisfied with the total reimbursement offered by the intermediary in their NPRs because it was calculated using the 1979 Malpractice Rule. Their dissatisfaction stems from an unlawful regulation which the intermediary was required to follow. The statute requires nothing more in the way of dissatisfaction.

B. The Statute Does Not Limit The Board Hearing To Items Which The Intermediary Has Adjusted.

The plain language of other portions of section 1395oo indicates that the scope of the hearing before the PRRB is broad, and is not limited solely to items for which the intermediary has written an audit adjustment.

1. Subsection (a) Provides That The Hearing Is About The Cost Report.

Subsection (a) provides that if a provider has filed a cost report and has met the other specified criteria, it "may obtain a hearing *with respect to such cost report*" (emphasis added). The statute does not say that the hearing is limited to intermediary adjustments to the cost report, but rather concerns the cost report as a whole.

This raises the issue of what constitutes a cost report. The "report" is not a single page or schedule, but rather a voluminous document with schedules, worksheets, and supplemental worksheets. (*See* checklists, first page of cost report excerpts, Jt. App. 35a-36a; 45a-46a). The Provider Reimbursement Manual (HIM-15) specifies which schedules and worksheets must be filed by each type of provider with its fiscal intermediary. The ultimate array of schedules and worksheets is determined by such questions as whether the provider is a hospital or nursing home, whether it is for-profit or non-profit, and which services it furnishes.

Acute general hospitals, such as the two Hospitals in question, are required to file with their intermediary, as part of the cost report, various schedules and worksheets. These include Worksheet A, "Reclassification and Adjustment of Trial Balance of Expenses," (Jt. App. 39a, 50a), Worksheet A-8, "Adjustments to Expenses," (Jt. App. 41a, 52a), and Worksheet D-8, "Apportionment of Malpractice Insurance Costs," (Jt. App. 58a-61a), each of which includes malpractice insurance premium costs.

Thus, the phrase "with respect to such cost report" in subsection (a) certainly includes costs of malpractice in-

surance, which must be entered on at least three worksheets of the cost report. Whether or not the intermediary adjusted those particular cost items in the process of making a final determination, the Hospitals are entitled to a hearing "with respect to such cost report", including the fact that the 1979 Malpractice Rule was required to be applied to their claim for reimbursement of malpractice insurance costs by means of Worksheet D-8.

When the *Athens I* panel described subsection (a) as "limit[ing] PRRB review to matters *raised by* the original cost report," 686 F.2d at 995 (emphasis added), the court then clearly erred. The operative statutory language in section 1395oo(a) is that a provider may obtain "a hearing *with respect to such cost report*." To substitute the words "raised by" for "with respect to" is unwarranted and is not supportable.

2. ***The Malpractice Insurance Costs Here At Issue Were Matters "Covered By Such Cost Report" Within The Meaning Of Subsection (d).***

Once a provider is entitled to a hearing, subsection (d) delineates a broad function for the PRRB:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report *and to make any other revisions on matters covered by such cost report* (including revisions adverse to the provider of services) *even though such matters were not considered by the intermediary* in making such final determination.

42 U.S.C. § 1395oo(d) (emphasis added).

Congress used an all-inclusive phrase, "matters covered by such cost reports", rather than a more limited phrase such as "intermediary adjustments." As the above discussion of "cost reports" indicates, the Hospitals included reference to their costs of malpractice insurance on at least three worksheets. There is no reasonable interpretation to

be made that the Hospitals' malpractice insurance costs are not "matters covered by [the] cost report."

This conclusion that the Board can review matters for which the intermediary did not write an adjustment is bolstered by the language in the rest of the sentence: the Board can make revisions on matters "even though such matters were not considered by the intermediary in making a final determination." Obviously, if an intermediary has written an audit adjustment on an issue, it has "considered" the matter. This phrase must therefore mean that the Board has the power to make revisions on matters where the intermediary has *not* written an audit adjustment, *e.g.*, self-disallowed costs. *St. Luke's Hospital v. Secretary of Health and Human Services*, 810 F.2d 325, 328 (1st Cir. 1987).

Because the interpretative focus by the Circuits has been on the *Athens* reading of section 1395oo(d), it is useful to analyze the *Athens* decisions as if they correctly characterized subsection (d) as the statutory grant of jurisdiction. The *Athens I* panel first concluded that subsection (d) is "clearly limited to revisions of matters covered by the original cost report and does not authorize the Board to consider new claims." *Athens I*, 686 F.2d at 995. This reading does not preclude review of self-disallowed costs, because they do appear in the cost report. *Adams House*, 817 F.2d at 591 ("a cost is 'covered by a cost report' if it was incurred within the period which is the subject of the report and is reflected in that report, even if it is not expressly claimed.")

In *Athens II*, the court again proceeded as if subsection (d) constituted the jurisdictional grant to the PRRB, and again its analysis is flawed. *Athens II* begins by specifically rejecting the Seventh Circuit's reading of the statute in *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337 (7th Cir.), *cert. denied*, 464 U.S. 830 (1983), on the basis that its reading of the statute ignores and would make meaningless that part of subsection (d) "limiting the PRRB's power 'to af-

firm, modify, or reverse a prior decision of a fiscal intermediary . . . and to make . . . revisions to *matters covered by [that] cost report.* ' " 743 F.2d at 6.[10] The *Athens II* court thereupon purports to read section 1395oo(d) "in light of the Board's functions set out by section 1395oo(a)." *Id.* However, as discussed above, the *Athens II* court misconstrued the language of subsection (a) with respect to the requirement that a provider be "dissatisfied".

An overriding flaw is that the *Athens II* court reaches an internally inconsistent position with respect to its interpretation of subsection (d). At the beginning of its decision, the court describes subsection (d) as "embodying two *separate* jurisdictional grants[:]" first, to affirm, modify or reverse an intermediary determination, and second, to make revisions on matters covered by the cost report not considered by the intermediary. *Id.* at 4 (emphasis added). The court expressly found that "[j]urisdiction exists if the terms of *either* of these two clauses are satisfied." *Id.* (emphasis added).

At the end of its tortured analysis of subsection (d), however, the *Athens II* court ignores its earlier and obvious reading of the language, and concludes that second grant of jurisdiction can be used *only if* the Board has exercised the first grant; that is, the Board can make revisions to matters

[10] The Court had previously erroneously described *St. Mary of Nazareth* as being the most expansive reading of § 1395oo(d), which would include jurisdiction for matters not disclosed to the intermediary through the cost reporting process, assuming that there had been no self-disallowance in that case. 743 F.2d at 5. However, in *St. Mary of Nazareth* the provider in fact had listed its patient telephone costs on its cost report and then had self-disallowed those costs in accordance with 42 C.F.R. § 405.310(j) (1983). *St. Mary of Nazareth*, 698 F.2d at 1340-41. Thus the holding of *St. Mary of Nazareth* must be limited to its facts—the Board has jurisdiction to hear self-disallowed costs which are part of the cost reporting process.

covered by the cost report under the second grant *only* as necessary to accomodate revisions made under the first grant. *Id.* at 9. *Athens II* justifies its conclusion on the grounds that its interpretation of subsection (d) is necessary to give meaning to both the Board's powers. *Id.* As the First Circuit noted, however, why would Congress have to write a special clause into the statute to give the Board the power to make revisions "necessary" to accommodate other provisions, when that power is inherent in the power to affirm, reverse or modify a decision before it? *St. Luke's Hospital,* 810 F.2d at 330.

While the First Circuit in *St. Luke's* is correct in its criticism of *Athens*, it, too, erred in its construction of subsection (d). The *St. Luke's* court read the words "shall have the power" as vesting the PRRB with a discretionary power to grant providers the right to be heard with respect to self-disallowed costs. 810 F.2d at 327.

This construction by the *St. Luke's* court is wrong for two reasons. First, as discussed above, it is subsection (a), not subsection (d), that establishes the PRRB's jurisdiction. And second, as the Ninth Circuit noted, the discretionary language "shall have the power" in subsection (d) refers to "the Board's options once an appeal is filed", not to the Board's power to refuse to hear an appeal at the outset. *Adams House,* 817 F.2d at 594. Moreover, to the extent the phrase "may obtain a hearing" in subsection (a) connotes any discretion at all, it is discretion on the part of the *provider* whether to seek a hearing at the Board, not discretion on the part of the Board to deny the hearing. "The Board has no discretion to reject on appeal . . . [for] the word 'may [obtain a hearing' in subsection (a)] connotes not contingency but entitlement." *Id.*

The reading of section 1395oo urged by the Hospitals, and adopted in *Adams House,* provides a more rational interpretation of the words "shall have the power" as that power applies to revisions of matters in the cost report not relied upon by the intermediary. Since the intermediary is merely a government contractor rather than a government

agency, the PRRB is the first time any component of the agency itself reviews the cost report and the intermediary's determination of reimbursement due. The provider should certainly have the right to have a government agency review the determination of the private government contractor, as well as to hear its challenge to agency policy.

C. *Section 1395oo(f)(1) Also Supports PRRB Jurisdiction Over Self-Disallowed Costs.*

The Eleventh Circuit in *Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d 1435 (11th Cir. 1987), *cert. pending*, No. 87-830, has provided an alternative analysis of the self-disallowance issue in another case where providers self-disallowed malpractice insurance costs. This analysis of the structure of section 1395oo supports the Hospitals' position that providers that self-disallow costs by following the Secretary's regulations are entitled to judicial review to challenge those regulations.

The court focused on the grant of judicial review found in the third through sixth sentences of section 1395oo(f)(1),[11] which apply to situations where a provider challenges a regulation and seeks to by-pass a hearing at the Board. Prior to the addition of these sentences, this section provided only for judicial review of a decision of the PRRB or, if the PRRB decision was reviewed by the Secretary, of the decision of the Secretary, and required a Board decision following a hearing as provided by subsection (d). Thus a provider that sought to challenge a regulation had to go through a full hearing at the Board, even though the Board had no authority to invalidate the regulation.

The *Tallahassee* court noted that the by-pass provisions added in 1980 permit a provider to obtain judicial review without a hearing at the Board, and refer only to subsection (a) and not to subsection (d). The court thus held that subsection (d), which describes the Board's function at such a hearing, is irrelevant to the analysis of the self-disallowance issue when a regulatory challenge is involved. 815 F.2d at 1461. It therefore logically concluded that *Athens* and its progeny, which focus on the language and meaning of subsection (d), are inapposite. *Id.* at 1462. It further held that so long as a provider meets the requirements of subsection (a), it is entitled to judicial review of its challenge to a Medicare regulation, even if it has self-disallowed costs by following the regulation in completing its cost report. *Id.* at 1463.

As indicated at page 7, above, the Hospitals were part of a group appeal for which expedited judicial review was sought. The PRRB granted expedited judicial review for the other providers but denied jurisdiction over the Hospitals because of their self-disallowances. That is the same posture that the hospitals in *Tallahassee* were in with respect to their self-disallowances. Accordingly, under the *Tallahassee* analysis, the Hospitals would prevail.

II. DEFERENCE TO THE SECRETARY'S INTERPRETATION OF THE STATUTE IS NOT WARRANTED.

The court of appeals in this case ruled against the Hospitals because it was bound by the decision in *Baptist Hospital East*. In that case, one provider followed the Secretary's regulations on bad debts and charity allowances when completing its cost report and then appealed to the PRRB to challenge those regulations. The Sixth Circuit recognized that, had the provider included costs not allowed by the regulations in its cost report, the intermediary had no authority to allow those costs, and that "in this situation, requiring a provider to claim reimbursement does not serve the purpose generally served by exhaustion requirements." Pet. App. 16a. The court thus acknowledged that the self-disallowance policy serves no legitimate purpose. Nonetheless, "even if we see little reason for requiring a provider to raise a claim before a

[11] See Appendix at 3a-4a. These sentences were added by the Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 955, 94 Stat. 2599, 2547-48 (1980).

body that cannot address it", the court felt obligated to "defer to the Secretary's interpretation [of the statutory scheme] where it is reasonable." Pet. App. 17a. The Hospitals contend that the Secretary's interpretation of the statute, which limits access to administrative and judicial review, is not reasonable and therefore deserves no deference.

Deference to agency interpretations is applicable only in situations where "the agency is required to apply [legal] standards to a particular set of facts." *I.N.S. v. Cardoza-Fonseca*, ___ U.S. ___, 107 S.Ct. 1207, 1221 (1987). The issue of the Board's jurisdiction is not such a situation. *Adams House*, 817 F.2d at 594. Rather, it involves the interpretation of a contested legal standard, and as such, is "a pure question of statutory construction for the courts to decide." *I.N.S. v. Cardoza-Fonseca*, 107 S.Ct. at 1221. The court, not the agency, is the ultimate arbiter of statutory construction. *Federal Election Commission v. Democratic Senatorial Campaign Committee*, 454 U.S. 27, 31-32 (1981); *Volkswagenwerk v. Federal Maritime Commission*, 390 U.S. 261 (1968). In analyzing the language of the statute, the agency's interpretation is not binding, *Bureau of Alcohol, Tobacco and Firearms v. Federal Labor Relations Authority*, 464 U.S. 89, 98 n. 8 (1983).

Moreover, where the agency is not deciding questions of regulatory policy, but rather, major issues of the relationship of the agency to the federal courts, the reasons for deference seem slim indeed. To give much weight to such an agency determination is to allow unwarranted weight to the decision of a party with adverse interests. As to other matters, the agency may theoretically be the disinterested protector of both the regulated group and the public interest. But as to its own freedom from review, the agency is an interested party.

In determining whether any deference is to be accorded to the Secretary's interpretation, the Court must first determine whether Congress has spoken to the issue, as

evidenced by the language of the statute and the legislative history. If it has done so, then the Court's inquiry is at an end. *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984). It is only if the Court finds that the statute is susceptible of multiple interpretations that the Court reaches the question whether the agency's interpretation is entitled to deference.

A. *The Statute Is Not Ambiguous.*

It is well established that a prerequisite to applying the principle of deference to agency construction of a statute is that the language of the statute be either silent or ambiguous. *Chevron*, 467 U.S. at 842-43. In this instance, the language of the statute is neither silent nor ambiguous. Rather, as discussed at length above, the plain language of subsection (a) provides that a hospital can obtain a hearing before the PRRB "with respect to [it] cost report," if it is "dissatisfied . . . as to the amount of total program reimbursement due. . . ." The statute does not limit the hearing only to items the intermediary has adjusted on the cost report, but includes *all* items listed in the cost report, even self-disallowed ones.

The language of subsection (d) is even more plain: the Board has the authority to make revisions "on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making the final determination." Congress could not have said any more clearly that the Board can review matters which the intermediary did not consider and for which the intermediary did not write an audit adjustment.

Interpreting the language of section 243(h) of the Immigration and Nationality Act of 1952, Pub. L. No. 82-414, § 243(h), 66 Stat. 163 (1952), this Court stated: "This ordinary and obvious meaning of the phrase is not to be lightly discounted. . . . With regard to this very statutory scheme, we have considered ourselves bound to assume that the legislative purpose is expressed by the ordinary meaning of the words used." *I.N.S. v. Cardoza–Fonseca*, 107 S.Ct. at 1213 (citations omitted).

If the same standard is applied here, there is no need to consider deference further. The ordinary and obvious meaning of the words "dissatisfied . . . as to the amount of *total* reimbursement due . . ." is that the provider is unhappy with the bottom line amount paid for services rendered. That language cannot be limited to mean only those amounts of reimbursement subjected to an audit adjustment. Not only would that limitation put an irrational gloss on the notion of dissatisfaction with the total amount due, but it eliminates whatever harmony there may be between that language and the language of subsection (d), which authorizes PRRB revisions to cost report items that have not been considered or relied upon by the intermediary. Read as the Hospitals urge, under subsection (a), providers have a right to be heard as to any costs in the cost report that are unpaid, whether or not those costs are the subject of an audit adjustment; and under subsection (d), the PRRB has the right to revise any matters in the cost report, whether or not the subject of an audit adjustment. This is a natural reading of the statute, and puts no strain on the construction.

In *I.N.S. v. Cardoza-Fonseca*, quoting *Chevron*, this Court also stated:

> The judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent. . . . If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect.

107 S.Ct. at 1221. The congressional intent drawn from the plain language of subsections (a) and (d) is that providers were to have a remedy if dissatisfied with the amount paid for their services. There is not the remotest suggestion that Congress intended the cost reporting process to be a trap for the unwary where the remedy is lost by following the Secretary's regulations and instructions in completing the cost report. Nor does the language suggest

that Congress intended that intermediaries were to be put to the task of recalculating cost reports containing entries contrary to the Secretary's regulations or instructions before a provider could challenge such regulations or instructions. Without Congressional intent to support it, the Secretary's interpretation is not entitled to deference.

B. ***The Legislative History Provides No Indication That An Audit Adjustment Is Required.***

Because the language of the statute is unambiguous, there is no need to even consider the legislative history of section 1395oo. However, a review of the legislative history indicates that the intent of Congress in enacting section 1395oo was to correct the previous absence of an administrative and judicial appeals process, not to put needless obstructions in the path of a provider which seeks to challenge a Medicare regulation. The House Ways and Means Committee acknowledged that "[u]nder present law there is no specific provision for an appeal by a provider of services of a fiscal intermediary's final reasonable cost determination," and that "it is desirable to prescribe in law a specific appeals procedure for settling disputed final determinations applying to the amount of program reimbursement." H.R. Rep. No. 231, 92d Cong., 1st Sess., *reprinted in* 1972 U.S. Code Cong. & Admin. News 4989, 5094. *See also* S. Rep. No. 1230, 92d Cong., 2d Sess. 248 (1972).

The only requirements Congress mentioned for appealing the final determination were the timely filing of a cost report, an amount in controversy of $10,000 or more, and the timely filing of an appeal. H.R. Rep. No. 231, *supra* at 5094; S. Rep. No. 1230, *supra* at 249. There is nothing in the legislative history to indicate that a provider must violate a regulation when filing its cost report in order to appeal.

C. ***The Secretary's Interpretation Is Not Reasonable.***

Assuming *arguendo* that the Court finds the intent of Congress, as evidenced by the language of the statute and

the legislative history, to be ambiguous, then the agency's interpretation of the statute can be afforded deference only if it is reasonable. *See I.N.S. v. Cardoza-Fonseca*, 107 S.Ct. at 1225 (Justice Scalia, concurring) and the cases cited therein.[12] The lack of practical considerations to sup-

[12] These decisions reconcile what appears to be a semantic conflict in *Chevron*. The Court states with respect to statutory interpretation that "if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute". 467 U.S. at 843. Juxtaposed with this is the statement that where the "legislative delegation to an agency on a particular question is implicit rather than explicit . . . a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency." *Id.* at 844. In each instance the question is one of statutory construction, with the later cases favoring an analysis based on reasonableness as opposed to whether it may be merely a permissible construction, of which there may be more than one. *See, e.g.*, Japan Whaling Ass'n v. American Cetacean Soc., 478 U.S. ____, 106 S. Ct. 2860, 2867-68 (1986); United States v. Fulton, 475 U.S. ____, 106 S.Ct. 1422, 1428 (1986). Moreover, it can hardly be argued that *Chevron* stands for the proposition that an administrative construction of statutory language that may be a permissible construction when reading the language in isolation, but unreasonable when read in the context of the legislative history, regulatory scheme and rights involved, should be given deference.

The reasonableness analysis is well described in a thoughtful article by Judge Breyer, where he says:

> A simpler course of judicial action, (and one that avoids the procedural thicket just mentioned) would be based upon a less literal reading of *Chevron*. The congressional "instruction" hypothetically implied from silence (and possibly other features of the situation) might be read, not as (1) "We delegate to the agency the power to create the law," but rather as (2) "Court, Pay particular attention to a reasonable agency interpretation of the law." This second instruction implies that, if the agency has not offered a reasonable interpretation of the statute in this case; if it has not considered the matter thoroughly; if, in *Skidmore*'s words, the agency's brief lacks "the power to persuade"; then the court should simply decide the question on its own. This second view makes practical sense from the perspective of judicial administration. [Citations omitted in original.]

Breyer, *Judicial Review of Questions of Law and Policy*, 38 Admin. L. Rev. 363, 379 (1986).

port the Secretary's interpretation, and the agency's inconsistent and hostile position on the issue, belie any assertion that the Secretary's interpretation is reasonable.

1. The Secretary's Policy of Denying Administrative And Judicial Remedies To Self-Disallowing Providers Lacks The Practical Underpinnings That Are Necessary To Support A Conclusion That It Is Reasonable.

The *Athens* court points to numerous practical considerations which, it believes, provide a rational basis for the Secretary's restrictive reading of the statute. A closer look at these considerations reveals that, in fact, there are no practical reasons whatsoever to require a provider to disobey a regulation, thereby causing the intermediary to make an adjustment to bring the cost report back into compliance with the regulation, in order for the provider to preserve its appeal rights.

a. The Secretary's Interpretation Imposes An Exhaustion of Remedies Requirement That Makes No Sense.

The *Athens I* court focused on what can be called exhaution of remedies considerations, concluding that to give the PRRB jurisdiction to hear new claims with respect to cost reports before it would have adverse effects. The court believed such jurisdiction would (1) significantly reduce the role of the intermediary, (2) deprive the PRRB of the intermediary's analysis and conclusions, and (3) make the PRRB the tribunal of original jurisdiction, thereby eliminating a tier of review and possibly slowing the reimbursement process for others. 686 F.2d at 997. None of these concerns have any merit with respect to costs that are self-disallowed in compliance with regulations.

(1) *Role of the intermediary.* In the instant case, disputing the validity of the Malpractice Rule with the intermediary would not reduce the intermediary's role, and would have achieved nothing, because the intermediary is bound by the Secretary's regulations and guidelines and could not have granted any relief. Consequently, any

arguments the Secretary may have that claims must be presented to the intermediary, in order that the intermediary should have an opportunity to resolve the issue, are not supported by exhaustion of remedies principles.

The remedy in the administrative scheme is the hearing at the PRRB and not the initial filing of the cost report with the intermediary, which is merely the provider's submission of its request for payment for services rendered filed in accordance with the regulations. Even the Sixth Circuit in *Baptist Hospital East*, which followed *Athens*, recognized that the intermediary was bound to apply the Secretary's regulations and that "in this situation, requiring a provider to claim reimbursement does not serve the purpose generally served by exhaustion requirements." 802 F.2d at 864-65. *Accord, Adams House*, 817 F.2d at 592.

Congress has already indicated that, in challenges to Medicare regulations, such futile procedures are to be avoided. As discussed above at page 22, in 1980 Congress amended section 1395oo(f)(1) to provide that, in situations where the Board was bound by the challenged regulation, the provider could ask the Board for a determination that the Board was "without authority to decide the question." Such a determination by the Board allowed the provider to bypass a hearing at the Board and proceed directly into district court on its challenge to the regulation.

The legislative history indicates that Congress created this by-pass provision to end pointless procedures. After describing the existing requirement that a provider must have a hearing at the Board even where the provider challenges a regulation by which the Board is bound, Congress states:

> The effect of this process has been to delay the resolution of controversies for extended periods of time and to require providers to pursue time-consuming and irrelevant administrative review merely to have a right to bring suit in a U.S. District Court.

H.R. Rep. No. 1167, 96th Cong., 2d Sess. 394, *reprinted in* 1980 U.S. Code Cong. & Admin. News 5526, 5757. *See also* remarks of Congressman Hettel, 126 Cong. Rec. 22218 (1980), *reprinted in Tallahassee Memorial Regional Medical Center*, 815 F.2d at 1460-61. Thus, where Congress has found that a procedure explicitly required by the statute is a useless exercise, it has not hesitated to avoid that procedure. The Secretary should not be allowed to mandate a similarly useless exercise where it is *not* required by the statute.

Given the mechanical audit function of the intermediary in reviewing the accuracy of the amount, classification and apportionment of costs entered in the cost report, the intermediary's role is not in any way diminished by giving the PRRB jurisdiction to review provider claims with respect to costs that have been self-disallowed in accordance with the Medicare statute, regulations and manual instructions. Indeed, when the provider follows such instructions in completing the cost report, the intermediary's role is facilitated, since the intermediary would otherwise have to recalculate the entire cost report after reapportioning malpractice costs to conform them to the methodology of the regulation.

Since in this case no useful purpose is served by requiring that claims be submitted to an entity that cannot grant relief, there are no policy considerations to support the agency's restrictive interpretation of the statute. Thus the self-disallowance rule cannot be viewed as a valid exercise of exhaustion of remedies, but should be treated as what it really is: an agency rule which precludes judicial review.

(2) *Deprivation of Intermediary Analysis.* Contrary to the concern expressed by the *Athens* court, the PRRB is not deprived of the intermediary's analysis and conclusions when it takes jurisdiction over self-disallowed costs. First, the intermediary's determination with regard to self-

disallowed costs would be nothing more than what has already been done by the provider itself, i.e., to apportion costs in accordance with the regulation. The only difference between a self-disallowance and the intermediary audit adjustment is that the intermediary includes a reference to the regulation or instruction on which the adjustment is based in the audit adjustment report. Secondly, because the intermediary cannot review the validity of the regulation, it has no analysis to offer. *Adams House,* 817 F.2d at 592; *Baptist Hospital East,* 802 F.2d at 865.

And third, to the extent that the self-disallowance involves a challenge to a manual provision which the PRRB can decide (as opposed to a regulation by which the Board is bound), the intermediary is a party to the PRRB proceedings. 42 C.F.R. § 405.1843 (1986). At the hearing in such a case, the intermediary can offer a full analysis and its conclusions with regard to the correctness of a manual instruction.

Accordingly, the loss of the intermediary's analysis that concerned the *Athens* court is hardly a basis for denying a provider the right to be heard in a challenge to a regulation or manual instruction that the provider followed in completing its cost report.

(3) *PRRB as original tribunal.* The *Athens I* panel's concern that the PRRB would become a "tribunal of original jurisdiction" arises from the court's erroneous characterization of the filing of a cost report as a "proceeding". This concern is groundless because, in fact, Congress fully intended the PRRB to be, at least in part, a tribunal of original jurisdiction.

The intermediary's primary function is to audit the costs of services provided and to administer payments, not to resolve policy disputes. S.Rep. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943, 1992-95. *See also Heckler v. Community Health Services of Crawford County,* 467 U.S. 51, 64 (1984). There is no

evidence that Congress intended that the intermediary be the initial reviewer of a provider's challenges to the Secretary's policies.

The Secretary's position that a provider must first somehow raise a dispute with the intermediary over the Secretary's regulations has the effect of comparing the filing and auditing of a cost report with the activity of a "trial" court prior to appeal to an appellate court. The activities are not comparable. The cost report is simply an accounting document which presents the provider's costs for that year in an accounting manner dictated by the Secretary and the Medicare statute. The intermediary's job is to audit that document in an accounting sense, not to act as a tribunal. Since the intermediary does not sit as a tribunal when it receives the cost report and there is no adversary process triggered by submission of the cost report, this concern provides no basis for denying a right to be heard.

The First and Ninth Circuits correctly recognized that the Board has a hybrid function. While it does "review" certain intermediary actions, Congress also gave the PRRB the role of an initial factfinder, with the power to hear witnesses from both sides and take new evidence. *St. Luke's Hospital,* 810 F.2d at 328; *Adams House,* 817 F.2d at 592-93. Thus Congress expressly indicated that the Board was to be the initial tribunal, not merely an appellate body.

b. *There Is No Possibility Of Stale Claims*

In addition to the exhaustion of remedies concerns, both *Athens* decisions raised the concern that allowing *de novo* claims to supplement the claims already before the PRRB, as the *Athens* providers were attempting to do, would render meaningless the time limits for filing cost reports and generate baseless appeals to protect against forgotten costs. *Athens I,* 686 F.2d at 997; *Athens II,* 743 F.2d at 7. This may be true with regard to claims for costs

that have not in any way been included in the cost report or otherwise presented to the intermediary. This concern, however, obviously does not apply with regard to self-disallowed costs for which the provider has appealed to the PRRB (whether included in the original request for hearing or later added to the hearing request pursuant to 42 C.F.R. § 405.1841(a) (1986)),[13] because those costs are already in the cost report. *Adams House*, 817 F.2d at 593.

It should be noted that in *Athens I*, the court took care to distinguish self-disallowed costs on the basis that, through the process of self-disallowing cost in accordance with the regulations or instructions, the provider had given the intermediary notice of the costs and the opportunity to determine whether reimbursement was proper. On rehearing, apparently prompted in part by the suggestion that at least one of the costs at issue would be deemed to be a self-disallowed cost, the court in *Athens II* retreated from its exception for self-disallowed costs, holding:

> At best, [the hospital's] claim with respect to the income tax costs can be characterized as a "self-disallowance." Its claim with respect to stock option cost is clearly not even that, for [the hospital] contends only that it was "directly related" to a category of cost in issue. Petition for Rehearing at 57. As such, the PRRB was correct in holding that it did not have jurisdiction to consider these costs because the intermediary was never given the opportunity to make a final determination about them.

743 F.2d at 10.

As part of that holding, *Athens II* distinguished between "listing a cost on the cost report and claiming reimbursement for a particular cost because the cost report lists both non-reimbursable and reimbursable costs." *Id.* at 3, n.2.

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[13] 42 C.F.R. § 405.1841(a) (1986) provides, in relevant part:

> . . . Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof.

Then, the court stated: "The essence of our holding today is that unless the provider includes a *category* of costs in its request for reimbursement, the intermediary is not obligated to determine whether reimbursement may be had for the cost items that make up that category." *Id.* (Emphasis in original.) If that was indeed the essence of the holding, then the self-disallowed costs at issue here *should* have been heard by the Board, since they *are* a part of a *category* of costs included in the cost report. *See* Worksheet D-8, Jt. App. 58a-61a.

c. *There Is No Possibility Of Frivolous Costs*

The *Athens II* court suggested that the interpretation urged by the Hospitals would have another set of significant adverse practical consequences. Those consequences were that a provider could "list every conceivable cost on its cost report, without claiming reimbursement, and hope that the intermediary will reimburse it for the reported but unclaimed costs, secure that it nevertheless will have until 180 days following the NPR to concoct some reasons to urge the PRRB for reimbursement of the unclaimed costs." 743 F.2d at 6. What the court apparently failed to recognize is that the provider already is required to list every conceivable cost in the cost report, and then to classify and categorize those costs as reimbursable or non-reimbursable in acccordance with the regulations and manual instructions. Since the intermediary has no option but to disallow costs claimed in contravention of manual instructions and regulations, it simply does not matter whether those costs were aggressively entered contrary to regulation, or whether the instructions or regulations were followed in completing the cost report. In addition, as the Ninth Circuit noted in response to *Athens*, any "frivolous padding" of cost reports is protected against by the anti-fraud provisions of 42 U.S.C. § 1395nn (1982).[14] *Adams House*, 817 F.2d at 592.

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[14] Pursuant to Pub. L. No. 100-93, § 4, 101 Stat. 680 (1987), this section will be moved but has not yet been assigned a new United States Code section number.

The *Athens II* court then expressed the concern that the provider would be able to claim reimbursement from the intermediary for costs on one basis and then recharacterize its costs and seek reimbursement on a totally different basis before the PRRB. 743 F.2d at 6. Unless the court's concern was that the provider would list malpractice premium cost as nursing costs or some other category of cost, and then seek a hearing on the basis that the nursing costs should have been paid as malpractice costs, this concern is without merit. Other than placing a number in the cost reporting form across from the various descriptions of the kinds of cost being listed, the provider does not "characterize" its cost for the intermediary.

d. *There Is No Conflict With The Reopening Regulations*

The *Athens II* court also was concerned that the interpretation that the PRRB has jurisdiction to hear issues not disputed with the intermediary would be "inconsistent with the reopening regulations provided by regulation . . . . [in that] if specific claims were not required, an intermediary's denial of a reopening request often could not be final, contrary to 42 C.F.R. § 405.1885(c) (1986)."[15] *Id.* at 7. This argument has meaning only in an *Athens*-type case, where a provider has appealed to the Board, then attempts to have the cost report reopened to include omitted costs. Even then, as the Ninth Circuit recognized, an "[a]ppeal to the Board does not force an intermediary to reopen its deliberation against its will. There is finality at the intermediary level." *Adams House*, 817 F.2d at 593.

The idea that this potential lack of finality should prevent Board jurisdiction stems from the incorrect notion that the Board exercises purely a power of review with no element of initial jurisdiction. *Id.*; *see also* pages 32-33, above. Moreover, the *Athens* court's concern as to the

[15] 42 C.F.R. § 405.1885(c) (1983) provides:

> Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

conflict with the reopening regulations is irrelevent to the issue of a right to be heard on self-disallowed costs which were on the original cost report and for which a provider has not requested reopening of its cost reports.

In summary, none of the alleged adverse consequences raised by the *Athens* court justify precluding the Board from taking jurisdiction over appeals of providers that self-disallow by following regulations or manual instructions. No reasonable purpose is served by disputing a regulation with an intermediary that is bound by the very regulation. The costs are timely listed on the cost report and are not stale. And finally, there is no conflict with the Secretary's reopening regulations. Without such practical underpinnings, and in light of the most natural and easy reading of the language of the statute, the Secretary's interpretation cannot be considered to be reasonable.

2. *The Secretary's Interpretation Is Only An Informal Policy, Was Not Developed Contemporaneously With The Statute, Has Not Been Consistently Applied, And Reflects The Agency's Hostility To Administrative And Judicial Review.*

The Secretary's interpretation that the PRRB has no jurisdiction to hear appeals of self-disallowed costs is contained nowhere in the Medicare regulations. To the extent the policy is arguably articulated anywhere in the Medicare Provider Reimbursement Manual, it appears only in sections dealing with fraud and abuse warnings.[16]

It is recognized that informal agency policies or guidelines may be accorded significantly less deference than administrative regulations, established pursuant to notice and comment provisions, which may have the force of law. *General Electric Co. v. Gilbert*, 429 U.S. 125, 143 (1976), *reh'g denied*, 429 U.S. 1079 (1977). The time-worn test to determine to what degree, if any, such informal policies are entitled to deference was set forth in *Skidmore v. Swift & Co.*: "The weight of [an agency's] judgment in a

[16] See discussion in Section IV, below.

particular case will depend on the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control." *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). *Accord, Morton v. Ruiz*, 415 U.S. 199, 237 (1974). Under this test, the Secretary's interpretation is not entitled to deference.

First, the Secretary's policy was not developed contemporaneously with the enactment of section. The Board did not begin to articulate the self-disallowance policy until the early 1980s, some eight years after the promulgation of the statute. To the extent they may be relevant at all, the manual provisions concerning the claiming of non-allowable costs in the context of prosecution for fraud were not issued until December 1978.

In an analogous situation, this Court has indicated its willingness to limit judicial deference of an administrative interpretation of a statute. In *General Electric Co. v. Gilbert*, the Court cited the test from *Skidmore v. Swift*, and concluded that the guideline at issue "did not fare well under these standards [as] it [was] not a contemporaneous interpretation of [the statute]. . . ." 429 U.S. at 142.

Moreover, even after the Secretary developed this interpretation, the agency has not consistently applied it, leaving providers in a situation of not knowing what the agency will do. The First Circuit pointed to at least four cases in which the PRRB accepted jurisdiction over self-disallowed cases. *St. Luke's Hospital*, 810 F.2d at 331.

In addition, the Eleventh Circuit has considered the merits of a case in which the PRRB originally exercised jurisdiction over self-disallowed costs. In *Charter Peachford Hospital Inc. v. Bowen*, 803 F.2d 1541 (11th Cir. 1986), the Court of Appeals specifically noted:

> . . . Although Charter Peachford did not originally claim reimbursement for the salaries on its 1980 cost report, it later appealed the intermediary's disallowance of these costs to the Provider Reimbursement Review Board . . . .

Id. at 1543. The PRRB exercised jurisdiction over the appeal of those costs, invoking its authority to hear matters not considered by the intermediary as contained in section 1395oo(d) and 42 C.F.R. § 405.1869 (1986).[17] This is evident from the excerpts of the transcript of the proceedings brought by Charter Peachford Hospital before the PRRB. *See* Jt. App. 64a-67a. Upon appeal to the courts, the Secretary did not challenge PRRB jurisdiction.

A final factor demonstrates that the Secretary cannot be expected to render a reasonable interpretation of statutory language relating to a provider's right to judicial review. Since the inception of the Medicare program, the Secretary has endeavored to deny providers both administrative and judicial process with regard to their claims that they have been short-changed for services provided to Medicare beneficiaries. All gains by the providers for any kind of fair process concerning disputed claims have been obtained only over obdurate resistance by the Secretary.

From the beginning of the Medicare program in 1966 through 1972, the Secretary offered *no* dispute resolution process for providers aggrieved by the level of Medicare reimbursement. Rather, the Secretary relegated provider complaints to informal discussions or review by representatives of the intermediary. During this period, the Secretary successfully fought and resisted provider access to the courts on such claims. *See, e.g., Schroeder Nursing Care, Inc. v. Mutual of Omaha*, 311 F. Supp. 405 (E.D.

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[17] 42 C.F.R. § 405.1869 (1986) provides:

> The Board shall have the power to affirm, modify, or reverse a determination of an intermediary with respect to a cost report and to make any other modifications on matters covered by such cost report (including modifications adverse to the provider or other parties) even though such matters were not considered in the intermediary's determination. The opinion of the majority of those Board members deciding the case will constitute the Board's decision.

Wisc. 1970); *Wilson Clinic & Hospital, Inc. v. Blue Cross of South Carolina,* 494 F.2d 50 (4th Cir. 1974).

The Courts, however, soon began to question the Secretary's failure to provide a fair process for dispute resolution and the Secretary's fight against judicial review. *See, e.g., Coral Gables Convalescent Home v. Richardson,* 340 F. Supp. 646 (S.D. Fla. 1972) ("This Court, like the Second Circuit in *Acquavella* . . . is disconcerted by defendants' contention that plaintiff is entitled to neither administrative nor judicial review . . ."); *Whitecliff, Inc. v. United States,* 536 F.2d 347, 349-51 (Ct. Cl. 1976), *cert. denied,* 430 U.S. 969 (1977).

For cost reporting periods ending on or after December 31, 1971 through June 30, 1973, the Secretary fashioned a more formalized dispute resolution process consisting of a "hearing" before a panel established by the provider's intermediary. 42 C.F.R. § 405.490 (1974). This process was found defective and an injunction issued in *St. Jude Manor Nursing Home, Inc. v. Richardson,* No. 72-681-Civ-J-S (M.D. Fla. Oct. 3, 1972), *reprinted in* Medicare and Medicaid Guide (CCH) ¶ 27,226). The Secretary strenuously resisted provider access to the federal courts following this hearing process. *See, e.g., Temple University v. Associated Hospital Service of Philadelphia,* 361 F. Supp. 263 (E.D. Pa. 1973); *Sacred Heart Hospital v. United States,* 616 F.2d 477, 482 (Ct. Cl. 1980) ("Defendant once again challenges this court's jurisdiction over a portion of this Medicare case. As to the years 1967 through fiscal year 1972, defendant apparently finally accepts this court's jurisdiction. . .").[18]

[18] The Secretary again tried to prevent providers from having any access to judicial review with respect to the implementation of PPS. In his Report to Congress on Hospital Prospective Payment For Medicare, the Secretary stated:

> Payment amounts, exceptions, adjustments, and rules to implement the prospective payment system would not be subject to any form of judicial review . . . The omission of judicial review follows the current statutory provisions related to determinations under Medicare Part B where judicial review is also prohibited. As with any service sold to the Government, the remedy for providers dissatisfied with the rate offered is to convince the purchasing agency that a higher rate is appropriate or, failing that, to refrain from offering services to the Government.

Report sent to House Committee on Energy and Commerce, 136 Cong. Rec. H 8573 (1982). Congress rejected this blatant attempt to foreclose all access to judicial review by amending section 1395oo(a) to specifically give hospitals a right to appeal their PPS payments. Pub. L. No. 98-21, § 602(h)(1), 97 Stat. 65 (1983). And in *Bowen v. Michigan Academy of Family Physicians,* 476 U.S. 667 (1986), this Court rejected the notion that all judicial review was prohibited under Part B, finding that the legality of a regulation setting forth the methodology used by the Secretary to compute Part B payments was subject to review.

Given the Secretary's history of resistance to judicial review and the courts' rejection of those attempts, the Secretary's present hard-line position should not be accorded the status of a reasonable interpretation or be made the basis for the denial of the providers' right to be heard.

III. SECTION 1395oo SHOULD NOT BE INTERPRETED TO CONTAIN AN IMPLIED DELEGATION OF DISCRETIONARY POWER TO THE SECRETARY OR THE PRRB TO LIMIT OR FORECLOSE ADMINISTRATIVE AND JUDICIAL REVIEW.

In *St. Luke's,* the First Circuit found that the PRRB's authority to revise aspects of the cost report that had not been considered by the intermediary constituted a discretionary power to assume or decline jurisdiction over claims for self-disallowed costs. That conclusion was not based upon any express delegation of power in subsections (a) or (d), but rather was a matter of interpretation. As discussed above at page 21, the *St. Luke's* interpretation was based upon a misreading of the statutory language. However, assuming *arguendo,* that such a reading could be supported, then the question must be asked whether the language of subsections (a) or (d) *should* be interpreted to include such a delegation of power to the agency. For the following reasons, the Hospitals suggest it should not.

First, it should be noted that the only express delegation in either subsection 1395oo(a) or (d) that gives the Secretary any power to limit the provider's access to administrative and judicial review is with respect to specifying the time within which the cost report must be filed with the intermediary. That does not constitute a delegation of power to interpret those subsections in a manner that forecloses review for self-disallowed costs. Such express power being lacking, it should not be implied.

In *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), this Court relied upon the presumption of reviewability to find a right to judicial review with respect to the method of determining reimbursement for physician services under Part B of the Medicare program. If the presumption of reviewability was sufficient to overcome the limitations of 42 U.S.C. § 405(h) (1982) within the context of *Michigan Academy*, it should militate against an interpretation of subsections (a) or (d) that would imply a discretionary power in the agency to foreclose administrative and judicial review by imposing threshold procedural requirements beyond those required by the statute. This is particularly the case where the statutory provisions to be interpreted constitute a broad congressional grant of administrative and judicial remedies for providers dissatisfied with the amount of reimbursement received for their services.[19]

In addition to the presumption of reviewability, there is another policy observed by this Court that operates

[19] Interpreting section 1395oo(g) (1982), the Eleventh Circuit in Memorial Hospital v. Heckler, 706 F.2d 1130 (11th Cir. 1983), *cert. denied*, 465 U.S. 1023 (1984) found that subsection (g) should not be read to preclude judicial review of a challenge to the Secretary's regulation listing patient telephone costs as an example of noncovered personal comfort items under section 1395y(a) (1982). The court stated:

> "To expand the non-reviewability of intermediary decisions to include policy decisions of the Secretary would not merely insulate from judicial scrutiny the finding of an intermediary. It would give the Secretary virtually unbridled discretion to prevent reimbursement through regulations. Such a result would run contrary to the presumption favoring judicial review.

Id. at 1133.

Giving the agency the discretionary power to foreclose review through agency interpretation of the threshold requirements for review operates to create a similar mischief. In this instance the Secretary can avoid being required to pay for services rendered by some providers while being made to pay others simply by imposing threshold jurisdictional requirements beyond those required in the statute which may not be met by some providers. In a second case involving the Secretary's attempt to restrict administrative and judicial review under section 1395oo(a) for claim under PPS, the D.C. Circuit found that "congressional intent is clear and there is no implicit delegation of authority to the Secretary to interpret the review provision." Washington Hospital Center v. Bowen, 795 F.2d 139, 147 n. 10 (D.C. Cir. 1986).

against an interpretation of section 1395oo that finds such an implied delegation to the agency. That policy arises from the fact that section 1395oo, granting administrative and judicial review against the Secretary, constitutes a waiver of sovereign immunity. In *Bowen v. City of New York*, __ U.S. __, 106 S.Ct. 2022 (1986), as part of the analysis of whether the Secretary's secret policies should toll the statute of limitations in 42 U.S.C. § 405(g) (1982), this Court stated:

> In construction of the statute [waiving sovereign immunity], we must be careful not to "assume the authority to narrow the waiver that Congress intended,". . . or construe the waiver "unduly restrictively".

Id. at 2029 (citations omitted). If this Court imposes such a standard itself, it hardly seems consistent to imply an interpretative power in the Secretary to impose threshold impediments not clearly required by statute. This particularly is the case where, as here, the entire thrust of the Secretary's conduct has been to seek to narrow or limit access to the congressionally granted waiver of sovereign immunity.

To the extent the *St. Luke's* court would read section 1395oo to delegate to the Secretary or the PRRB an im-

plied discretionary power to limit or restrict the waiver of sovereign immunity, it is incorrect. It also runs counter to the presumption of reviewability. In short, as discussed above, there are ways to read section 1395oo which provide the desired administrative and judicial remedies for providers wishing to claim reimbursement for self-disallowed costs without vesting discretionary jurisdiction in the Secretary or the PRRB. Those readings should be preferred over the *St. Luke's* reading.

IV. THE SECRETARY CANNOT PRECLUDE JUDICIAL REVIEW WITHOUT NOTICE

Assuming *arguendo* that the Secretary's policy concerning self-disallowed costs is consistent with the statute and is therefore permissible, that policy appears nowhere in Medicare regulations. Providers are told to fill out cost reports in a manner consistent with applicable law, regulations and policy manuals. They are also admonished not to commit fraud and abuse, which includes making claims for payments not allowable under the regulations and manual. Providers are not told that the only way they can preserve their appeal rights is to violate both of these requirements.

To require the preservation of claims according to procedures announced *post hoc* would, at best, require a provider to read the agency's mind. The fact is that the Hospitals were not given notice by the agency or the intermediary that, when they complied with the Secretary's regulations in completing their cost reports, they were forfeiting their appeal rights. Under these circumstances, the Secretary cannot preclude judicial review, for to penalize a person for failing to follow an unpublished or, indeed, a non-existent rule raises serious due process issues. *See, e.g., Brinkerhoff-Faris Trust & Savings Co. v. Hill,* 281 U.S. 673, 678-79, 681-82 (1930).

The *Athens II* court referred to section 2425.1 of the Provider Reimbursement Manual (HIM-15) as establishing a "formal procedure by which providers could . . . preserve appeal rights by including the disputed costs in

their allowable costs and disclosing the existence of such costs to the Medicare intermediary." 743 F.2d at 10. *See also St. Luke's Hospital,* 810 F.2d at 332. Although this provision existed since 1979, *id.,* by its own terms it does not apply to the factual scenario faced by these Hospitals.

Section 2425.1 deals with possible referrals to the United States Attorney for consideration of criminal and/or civil prosecution for fraud where a provider claims reimbursement for costs not allowed under the regulations. It provides as follows:

> There will be no referral to the U.S. Attorney if the allowability of a cost report item or items have been or are being disputed, and the provider clearly indicates on the *subsequent* cost report that the items are included, and the reason for inclusion (i.e., such as to preserve the provider's right to appeal, or other legal rights.) (Emphasis added.)

As evidenced by the underscored language, this provision applies only to a situation in which a provider seeks reimbursement of a cost that was disallowed on a previous cost report and the previous disallowance is still under appeal.

This is confirmed by HCFA Transmittal No. 213, December 1978, which accompanied the issuance of section 2425.1:

> *2425.1, Nonallowable Cost Report Entries,* is a new section which manualizes current procedures dealing with the problem of repeated (year after year) entries of nonallowable items on Medicare cost reports. Where a provider knowingly includes *previously disallowed costs,* which are not being appealed, on a subsequent cost report, the provider will be notified of possible referral to the U.S. Attorney for consideration of criminal and/or civil prosecution if the disallowed costs are included in a future cost report. (Emphasis added.)

Thus, where costs are disallowed in one year and the provider either does not appeal or loses an appeal, if the pro-

vider attempts to claim the same costs in the next year, the intermediary may refer the case for prosecution. If, on the other hand, the provider appeals the disallowance in the first year and wishes to continue to appeal in subsequent years, no referral will be made if the provider discloses this intent on the cost report. However, this section provides no instructions on how a provider is to preserve its appeal in the first year. Nor can it reasonably be construed to provide notice that if a provider completes its cost report by following the regulations, it has waived any right to challenge that regulation in the PRRB and the courts.[20]

[20] The *St. Luke's Hospital* decision states that the accompanying memorandum indicates section 2425.1 was issued "so that providers will not be discouraged from exercising their statutory rights of appeal." 810 F.2d at 332. This refers to Transmittal No. 225, August 1979, which states in full:

> *Section 2425.1, Nonallowable Cost Reports Entries,* is revised so that providers will not be discouraged from exercising their statutory right to appeal. There is new language to show that repeated inclusion of nonallowable entries in cost reports could result in provider termination from the program.

This language again indicates that section 2425.1 is directed at *repeated* claims for nonallowable costs, and does not apply in this situation.

CONCLUSION

For the foregoing reasons, the decision of the court of appeals should be reversed, and the case should be remanded with instructions to pay the Hospitals in the same manner as the other providers in the case below.

Respectfully submitted,

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NOVEMBER 1987

APPENDIX

STATUTE INVOLVED

42 U.S.C. § 1395oo. Provider Reimbursement Review Board.

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if –

(1) such provider –

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied

with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragragh (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) Appeals by groups

The provisions of subsection (a) of this section shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

* * *

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

* * *

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and

has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly be several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5, notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

* * *

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No. 86-1764

In the Supreme Court of the United States

OCTOBER TERM, 1987

BETHESDA HOSPITAL ASSOCIATION, ET AL., PETITIONERS

v.

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE RESPONDENT

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54 pp

QUESTION PRESENTED

Whether the Provider Reimbursement Review Board may consider a health care provider's claim that it is entitled to reimbursement under the Medicare statute for a particular cost when the provider failed to seek reimbursement for that cost from its fiscal intermediary and did not otherwise reserve before the intermediary its right to seek reimbursement for that cost.

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In the Supreme Court of the United States

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BETHESDA HOSPITAL ASSOCIATION, ET AL., PETITIONERS

v.

OTIS R. BOWEN, SECRETARY OF
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ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
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BRIEF FOR THE RESPONDENT

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-8a) is reported at 810 F.2d 558. The opinion of the district court (Pet. App. 29a-51a) is reported at 608 F. Supp. 1360. The opinion of the Provider Reimbursement Review Board (Pet. App. 52a-58a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on February 2, 1987, and a petition for rehearing was denied on July 1, 1987 (J.A. 68a). The petition for a writ of certiorari was filed on May 2, 1987, and was granted on October 5, 1987. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTE INVOLVED

The relevant portions of 42 U.S.C. (& Supp. III) 1395*oo* are set forth in the addendum to this brief.

STATEMENT

1. At the time of the events at issue in this case, all "providers" of health care services to Medicare beneficiaries were reimbursed by the Secretary of Health and Human Services on an annual basis for the "reasonable cost" of those health care services. 42 U.S.C. (& Supp. III) 1395f(b), 1395x(u) and (v)(1)(A).[1] Under this system, the Secretary makes periodic payments to a provider over the course of the year based upon an estimate of the amounts owed to the provider. 42 U.S.C. (& Supp. III) 1395g; 42 C.F.R. 413.60. At the end of the year, the provider submits a claim for reimbursement in the form of a "cost report." See 42 U.S.C. (& Supp. III) 1395f(a); 42 C.F.R. 413.20(a) and (b), 413.24(f).[2] The cost report is "a lengthy document consisting of numerous schedules, worksheets, and supplemental worksheets. * * * [A] cost report, when completed, is approximately three-quarters of an inch thick" (*Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d 1, 3 (D.C. Cir. 1984)). Providers list on the worksheet cost items for which they do not seek reimbursement because those cost items supply background information that supports the provider's cost claims. See J.A. 34a-53a, 59a-61a (excerpts from petitioners' cost reports).

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[1] This case concerns payments under "Part A" of the Medicare statute, which provides coverage for "the costs of hospital, related post-hospital, home health services, and hospice care" (42 U.S.C. 1395c). As a result of amendments to the Medicare statute, some providers of such services are now paid predetermined rates for most of those services; other providers continue to receive reimbursement for their "reasonable" costs under the methodology described in the text. See Br. for Resp. 13-14.

[2] The report is due three months after the end of the provider's fiscal year. The provider may obtain a 30-day extension of the due date for "good cause." 42 C.F.R. 413.24(f)(2).

The cost report is submitted to the provider's "fiscal intermediary" for review. The intermediary, generally a private insurance company, is an entity that, pursuant to a contract with the Secretary, acts as the Secretary's agent in reviewing the provider's claims and determining the amount of reimbursement owed to the provider. See 42 U.S.C. (& Supp. III) 1395h; 42 C.F.R. 421.3, 421.100-421.128. The intermediary audits the cost report and issues a Notice of Program Reimbursement specifying the total amount of reimbursement due to the provider and explaining any adjustments to the costs claimed by the provider. See 42 C.F.R. 405.1803. The reimbursement award specified in the Notice of Program Reimbursement is compared to the Secretary's payments to the provider. Any deficiency is paid by the Secretary and any overpayment is repaid by the provider. 42 C.F.R. 405.1803(c), 413.60.

If a provider has timely filed its cost report and is "dissatisfied with [the intermediary's] final determination * * * as to the amount of total program reimbursement due the provider" or has not received a final determination on a "timeiy basis," the provider "may obtain a hearing with respect to such cost report" before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. (& Supp. III) 1395*oo*(a)(1); see also 42 C.F.R. 405.1835.[3] The PRRB is authorized by statute (42 U.S.C. 1395*oo*(d)) to

> affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such a cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

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[3] Review by the PRRB is available only if the amount in controversy is $10,000 or more and the provider's request for a hearing is timely filed (42 U.S.C. (& Supp. III) 1395*oo*(a)(2) and (3)).

The Board's decision is final unless the Secretary reverses, affirms, or modifies the decision within 60 days. The Board's decision—or the Secretary's modified decision, if any—is subject to judicial review in federal district court pursuant to the Administrative Procedure Act. 42 U.S.C. (& Supp. III) 1395*oo*(f)(1)); 42 C.F.R. 405.1875-405.1877.[4]

The statute permits providers to take a second, more expeditious route into federal district court in certain circumstances. A provider may obtain direct judicial review of "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines * * * that it is without authority to decide the question." 42 U.S.C. (& Supp. III) 1395*oo*(f)(1); see also 42 C.F.R. 405.1842.

2. Petitioners are two hospitals that have been certified as providers of services under the Medicare program. In their cost reports for 1980 petitioners computed their claims for malpractice insurance premium reimbursement in accordance with the then-current regulation governing reimbursement for such costs. As the court of appeals observed, "[t]he hospital's cost reports thus included a claim for reimbursement for malpractice insurance costs, but * * * effectuated a 'self-disallowance' " of such malpractice insurance costs in excess of those allowed under the 1979 Rule. Because these hospitals complied with the Secretary's regulation and cost report instructions, there was no need for the fiscal intermediary reviewing their cost reports to make an audit adjustment with respect to the malpractice insurance issue before issuing a Notice of Program Reimbursement" (Pet. App. 5a).

Together with more than 50 other Ohio hospitals, petitioners filed an appeal with the Provider Reimbursement Review Board Challenging the regulation governing the

[4] A final reimbursement decision may be reopended by the intermediary, the Board, or the Secretary in certain circumstances. See 42 C.F.R. 405.1885.

reimbursement of medical malpractice insurance premiums. The Board assumed jurisdiction over the claims of the more than 50 hospitals that had raised this issue in their cost reports. However, it held that it lacked jurisdiction over petitioners' claims because "the malpractice issue was not raised in the * * * cost report(s); nor have any amended costs report(s) been accepted by the intermediary on this issue; nor have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue" (Pet. App. 52a). The Board stated that "the provider must have claimed the cost in its filed cost report to give rise to any controversy. Without any notice of a claimed cost on a cost report, the intermediary is precluded from considering the matter and making any final determination for that particular item * * *. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction" (*id.* at 54a). Thus, "[w]hen the provider files a cost report, the particular cost must be claimed therein or [the provider must] state its claim and disclose its position on an issue which was not done in this case" (*ibid.*).[5]

Petitioners sought judicial review of the Board's determination, and the district court reversed (Pet. App. 29a-51a). It concluded that the Board's review of the intermediary's determination "need not be limited to costs claimed by the provider to the intermediary in the cost report" (*id.* at 34a.).[6]

[5] The Board permitted the hospitals that had raised the issue before the intermediary to seek direct judicial review of their challenge to the malpractice insurance cost reimbursement determination, finding that the Board lacked authority to decide the hospitals' claim that the regulation governing reimbursement was invalid (see 42 U.S.C. (& Supp. III) 1395*oo*(f)(1)).

[6] The district court also invalidated the malpractice insurance cost reimbursement rule (Pet. App. 42a-59a).

3. The court of appeals, in turn, reversed the district court's decision. Relying upon its prior decision in *Baptist Hospital East* v. *Secretary of Health & Human Services*, 802 F.2d 860 (6th Cir. 1986), the court concluded that the Board lacks jurisdiction over "claims by providers who • • • self-disallowed reimbursement and • • • failed to challenge the Secretary's regulations before the fiscal intermediary" (Pet. App. 6a). The *Baptist Hospital East* court had observed that the contrary interpretation of the statute—permitting the Board to act where the provider did not claim reimbursement—"renders the second part of the jurisdictional grant [in Section 1395*oo*(d)] meaningless" and "places an irrational gloss on the statute" (802 F.2d at 865). The construction of the statute adopted by the court instead requires a provider "to present a coherent claim for reimbursement at the time it files its cost report. It may not present claims to its intermediary, await the intermediary's decision, and then decide based upon its success before the intermediary whether to raise additional claims before the Board" (*ibid.*).[7]

[7] The court of appeals in the decision below rejected petitioners' claim that a contrary result was required by this Court's decision in *Bowen* v. *Michigan Academy*, 476 U.S. 667 (1986). It observed that *Michigan Academy* "dealt only with the right to judicial review in the absence of meaningful administrative review procedures" (Pet. App. 6a). Here, by contrast, there is an administrative review scheme, and the issue is whether "the *steps* in [the administrative review] process • • • include submission of a 'claim' before the fiscal intermediary as a prerequisite to PRRB and judicial review, in essence an exhaustion requirement" (*id.* at 7a (emphasis in original)).

With regard to the challenge to the malpractice reimbursement rule advanced by the hospitals that had properly preserved the issue, the court held that a newly-promulgated rule governing malpractice cost reimbursement could not be applied retroactively to the cost years at issue in this case. It therefore upheld the district court's award of additional reimbursement to these hospitals. Pet. App. 3a-4a. Petitioners' cost reports have been reassessed under the newly-promulgated rule and additional reimbursement was awarded to petitioners. Petitioners are in error in stating (Br. 11 n.9) that the Secretary may conclude

SUMMARY OF ARGUMENT

When Congress established the Medicare program in 1965, it vested in the Secretary the authority to determine the proper amount of reimbursement due providers of health services to Medicare beneficiaries. However, Congress did not direct the Secretary to create a new administrative apparatus to rule upon providers' reimbursement claims. It anticipated that most providers would nominate a private insurance company to "serve as a fiscal intermediary between themselves and the Federal Government"; the intermediary would enter into an agreement with the Secretary pursuant to which it would "determine the amount of payments due upon presentation of provider bills and make the payments." H.R. Rep. 213, 89th Cong., 1st Sess. 45 (1965). Although the Secretary retained the authority to review the intermediaries' determinations, the statute did not mandate any administrative or judicial review of those determinations.

The Provider Reimbursement Review Board was created by Congress in 1972 in response to providers' complaints about the arbitrariness of intermediaries' reimbursement decisions and the lack of any mechanism for administrative or judicial review of those decisions. The statute governing the Board's jurisdiction states in pertinent part that a provider may obtain a hearing before the Board if

that this new rule should not be applied to providers that failed to challenge the 1979 cost reimbursement rule before their intermediaries. The new rule applies to all cost reports that were open or subject to reopening at the time of the rule's promulgation without regard to whether a provider challenged the prior rule (see 51 Fed. Reg. 11188 (1986)). Petitioners, like the other providers challenging the malpractice insurance cost reimbursement rule, are not satisfied with the level of reimbursement under the newly-promulgated rule and contend that they are entitled to reimbursement under the more favorable pre-1979 rule. It is the latter claim that the court below found to be barred by petitioners' failure to raise the issue in the cost reports.

it "is dissatisfied with a final determination of the organization serving as its fiscal intermediary • • • as to the amount of total program reimbursement due the provider • • •" (42 U.S.C. (& Supp. III) 1395*oo*(a)(1)(A)(i)). The Secretary has construed this language to incorporate what is in effect an exhaustion requirement: a provider's right to obtain a hearing before the Board extends only to reimbursement claims raised by the provider in its cost report submitted to the fiscal intermediary. The question presented in this case is whether the Secretary's interpretation of the statute should be upheld or whether, as petitioners assert, the statute confers a right to a hearing with respect to issues that the provider has failed to present to its intermediary.

The text of Section 1395*oo*(a)(1)(A)(i) makes clear that a provider must present a reimbursement claim to its intermediary in order to obtain the right to invoke the Board's jurisdiction. A provider can be "dissatisfied" with the intermediary's determination only when the intermediary's reimbursement award falls short of the amount of reimbursement that the provider sought before the intermediary. If the intermediary awards the provider the amount of reimbursement that the provider itself requested in its cost report, the provider cannot be dissatisfied with the intermediary's action; it can only be dissatisfied with its own reimbursement request.

The legislative history provides additional support for the Secretary's interpretation of the statute. As we have discussed, Congress added the Board to the preexisting provider reimbursement process in response to providers' requests for an impartial appellate tribunal. Nothing in the legislative history indicates that Congress intended to alter the prior practice under which all reimbursement claims were submitted to the intermediary. Congress's intent—which is manifested as well in several related provisions of the statute—was to create an *appellate* tribunal to review

disputes between a provider and its intermediary. It would be contrary to that intent to require the Board to hear claims in the first instance in the absence of any dispute between the provider and its intermediary.

Finally, the Secretary's interpretation of the statute is eminently reasonable. The Medicare reimbursement process is a vast administrative undertaking: approximately 15,000 providers file annual cost reports that are several hundred pages in length. The primary responsibility for reviewing the cost report and determining the proper amount of reimbursement lies with the fiscal intermediary; the provider's claims clearly can be processed most efficiently if the intermediary considers all of the claims at the same time. Permitting the provider to raise new reimbursement claims before the Board would require the Board to duplicate the intermediary's efforts and expend its own scarce resources performing a task that could have been accomplished by the intermediary. The Secretary's exhaustion requirement also ensures that the Board will have the benefit of the intermediary's expert determination in the event the provider brings the matter before the Board.

Contrary to petitioners' assertions, these policies apply even if a reimbursement claim is one that the intermediary lacks authority to grant because it rests upon a challenge to a regulation. This Court has determined that exhaustion is appropriate in such circumstances to determine whether the claim does in fact turn upon the challenge to the governing regulation, as well as whether the claim is otherwise invalid or cognizable under a different statutory or regulatory provision. See *e.g.*, *Heckler* v. *Ringer*, 466 U.S. 602, 618-620 & n.12, 623-624 (1984). That conclusion is equally applicable to the present context.

Nor does the requirement that all claims be raised in the cost report work a hardship upon providers. Providers are sizeable institutions that already devote substantial resources to the preparation of the cost report; it should require little additional effort to ensure that all reimburse-

ment claims are included in that report. In view of that fact, and the need for clear procedural rules in an administrative undertaking as vast as the Medicare reimbursement process, the Secretary's interpretation of the statute should be upheld.

Even if the Courts were to disagree with our principal submission and conclude that the Board's jurisdiction may be invoked by a claim not previously presented to the intermediary in the cost report, a provider nevertheless should not be able to compel the Board to adjudicate such a claim in every case. The principles underlying the general rule that an appellate court will not consider an issue raised for the first time on appeal are equally applicable here. The Board should therefore be free, in the exercise of its discretion, to conclude that it will not consider a reimbursement claim that was not advanced before the intermediary.

ARGUMENT

THE PROVIDER REIMBURSEMENT REVIEW BOARD LACKS JURISDICTION OVER PETITIONERS' CLAIMS

Appellate tribunals, whether courts or components of administrative agencies, do not as a general rule consider claims raised for the first time on appeal. Requiring a party to present its claims to a trial-level decisionmaker furthers important policies of efficiency and deference to the expertise and record-developing capacity of those decisionmakers. Petitioners' interpretation of the statutory provision at issue in this case would turn that principle on its head by *requiring* an appellate tribunal—the Provider Reimbursement Review Board (PRRB)—to consider a reimbursement claim asserted by a provider even though the provider failed to present the claim to its fiscal intermediary. Nothing in the relevant statutory language or legislative history suggests that Congress intended such an extraordinary result. To the contrary, Congress created only a limited appellate remedy when it established the

PRRB. Fiscal intermediaries were to remain the principal decisionmakers in the reimbursement process; the Board's role was that of a referee in disputes between providers and their intermediaries. Because no such dispute can arise when a provider fails to raise a claim before its intermediary, a provider is not entitled to a hearing before the Board with respect to a claim that the provider did not first raise before the intermediary.[8]

A. A Provider May Invoke The Board's Jurisdiction Only When It Seeks Review Of An Issue Raised Before Its Fiscal Intermediary

1. Section 1395*oo* Limits The Board's Jurisdiction to Cases in which the Provider Seeks Review of a Claim Raised Before Its Intermediary

The starting point in any case of statutory construction is, of course, the language of the statute being construed. See, *e.g.*, *United States* v. *James*, No. 85-434 (July 2, 1986), slip op. 6. The relevant statute here is 42 U.S.C. (& Supp. III) 1395*oo*, which both establishes the Provider Reimbursement Review Board and delineates the Board's authority. We agree with petitioners (Br. 13-14) that Section 1395*oo*(a)(1)(A)(i) is the subsection most directly relevant in determining the circumstances in which a provider may invoke the Board's jurisdiction. We submit, however, that petitioners' interpretation of that provision cannot be reconciled with the statutory text. Viewed in the context of Section 1395*oo* as a whole, that language makes clear that the PRRB may only consider cases in which a provider seeks review of an issue that the provider previously raised before its fiscal intermediary.

a. Section 1395*oo*(a)(1)(A)(i) states that a provider may "obtain a hearing [before the PRRB] with respect to

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[8] Under the Secretary's interpretation of the statute, a provider may raise a claim before its intermediary either by claiming reimbursement for a particular amount in the cost report or by expressly noting its disagreement with the policy or regulation governing the reimbursement issue. See Pet. App. 52a-54a.

[its] cost report" if the provider "is dissatisfied with a final determination of the organization serving as its fiscal intermediary * * * as to the amount of total program reimbursement due the provider * * *." As a matter of both common sense and common usage, a provider can be "dissatisfied" with the intermediary's determination only when the intermediary's reimbursement award falls short of the amount of reimbursement that the provider sought before the intermediary. If the intermediary approves the provider's treatment of its own costs and awards the provider the amount of reimbursement that the provider itself requested in its cost report, the provider cannot be dissatisfied with the intermediary's action; it can only be dissatisfied with the request for reimbursement set forth in its own cost report. As one lower court has observed, "[i]t would be anomalous * * * to say that a provider can appeal only when 'dissatisfied' while allowing the provider to obtain review of an intermediary's refusal to reimburse the provider for a cost it did not even claim. * * * If a provider is unhappy with the reimbursement the intermediary allowed in such a case, it is the fault of the provider and not of the intermediary." *Athens Community Hospital, Inc.*, 743 F.2d 1, 6 (D.C. Cir. 1984); see also *North Broward Hospital District*, 808 F.2d 1405, 1409 (11th Cir. 1987), petition for cert. pending, No. 86-1986; *Community Hospital* v. *Health and Human Services*, 770 F.2d 1257, 1262 (4th Cir. 1985).

Petitioners assert (Br. 15-16) that a provider is "dissatisfied" within the meaning of Section 1395*oo*(a)(1)(A)(i), and therefore entitled to invoke the Board's jurisdiction, if the provider experiences a subjective feeling of dissatisfaction upon learning of the total reimbursement award. But the statute does not authorize review by the Board when the provider is "dissatisfied" in some general sense entirely unrelated to the intermediary's actions. It specifically requires that the provider be dissatisfied with a "final * * * determination of the * * * fiscal intermediary." Petitioners' interpretation essentially

reads the dissatisfaction language out of the statute: on their reading, any provider that seeks Board review of the intermediary's determination would be, simply by virtue of its decision to seek further review, a dissatisfied provider. Such a construction, which would render a provision of the statute essentially meaningless, is not favored. See *Bowsher* v. *Merck & Co.*, 460 U.S. 824, 833 (1983) (referring to the "settled principle of statutory construction that [the Court] must give effect, if possible, to every word of the statute"); *Fidelity Federal Savings & Loan Ass'n* v. *De La Cuesta*, 458 U.S. 161, 165 (1982).[9]

Other provisions of the statute confirm that a provider is "dissatisfied" only when the intermediary does not award the provider all of the reimbursement that the pro-

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[9] Petitioners state (Br. 15) that the statute requires "that the provider be dissatisfied with the *total* amount of reimbursement offered in the NPR," and that "the dissatisfaction [need not] be with respect to a particular intermediary audit adjustment" (emphasis in original). We agree that the provider must be dissatisfied with the total award. But the statute requires dissatisfaction with the "final * * * determination of * * * the fiscal intermediary" as to the total award. And the provider can be dissatisfied with the *intermediary's* determination of the amount of reimbursement only if the total award is less than the amount of reimbursement sought by the provider because the intermediary did not accept one or more of the provider's reimbursement claims.

Petitioners also state (Br. 15) that the provider must "be dissatisfied at the time it receives its [notice of program reimbursement], not beforehand." But that test is satisfied by our interpretation of the statute—the provider is dissatisfied because it learns that the intermediary has rejected one of its claims for reimbursement. Petitioners assert (Br. 16) that our reading of the statute is "not plausible" because Congress would not have intended to require providers to advance in the cost report a reimbursement claim that the intermediary lacked the authority to resolve in their favor, such as a claim resting upon a challenge to the Secretary's reimbursement regulations. As we discuss below (at 15), however, Congress imposed precisely such a requirement when it amended the statute in 1980. In addition, petitioners ignore the fact that their construction of the statute would allow any reimbursement claim, even a claim that does not rest upon a challenge to a regulation, to be raised before the Board in the first instance.

vider has claimed. Cf. *Commissioner* v. *Engle*, 464 U.S. 206, 223 (1984) (referring to other, related, portions of a statute in order to ascertain the meaning of a particular provision); *FBI* v. *Abramson*, 456 U.S. 615, 625-627 (1982) (same). First, Congress denominated the administrative body established by Section 1395*oo* the "Provider Reimbursement *Review* Board" (see 42 U.S.C. 1395*oo*(a)). The term "review" in the Board's name indicates that the Board's function is to review the reimbursement determinations of fiscal intermediaries, not to make those determinations in the first instance.

Second, Board review is available to a provider only when "the amount in controversy is $10,000 or more." 42 U.S.C. 1395*oo*(a)(2); see also 42 U.S.C. 1395*oo*(b) (group appeals permissible if "the amount in controversy is, in the aggregate, $50,000 or more"). Petitioners' interpretation of the statute would make the amount in controversy requirement difficult to administer. When the intermediary rejects a claim for reimbursement set forth in the cost report, it is easy to establish the amount in controversy: the intermediary's determination need only be compared to the provider's initial claim. If a provider may raise new claims before the Board, however, the Board will have to examine for itself in the first instance the amount placed in controversy by the provider's claim. Petitioner's construction would also make it easy to evade the amount in controversy limitation. A provider dissatisfied with its intermediary's determinations but otherwise unable to obtain Board review because $10,000 was not at stake could reach the required dollar amount by simply adding several new reimbursement claims at the time of its appeal to the Board. Since it could be so easily circumvented, the amount in controversy requirement would cease to be a meaningful limit upon the Board's jurisdiction.

Finally, any uncertainty about the meaning of Section 1395*oo*(a)(1)(A)(i) is resolved by the portion of Section 1395*oo*(f)(1) that permits expedited judicial review of certain reimbursement determinations when the Board determines that it lacks the authority to adjudicate the provider's claim. Section 1395*oo*(f)(1) states that "[p]roviders shall * * * have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines * * * that it is without authority to decide the question." This provision, which was added to the statute in 1980, is the only part of Section 1395*oo* other than Section 1395*oo*(a)(1)(A)(i) that addresses the prerequisites for Board jurisdiction. By stating that a provider may obtain "judicial review of any *action* of the fiscal intermediary" (emphasis added), Congress made clear that the rejection (or at least nonacceptance) by the intermediary of the provider's claim is a condition precedent for expedited judicial review.[10] Since the expedited review provision was intended to provide a direct route into court for all claims resting upon a controlling question of law or regulation that otherwise would be considered by the Board (see H.R.

[10] Petitioners may argue that the intermediary "acts" when it awards the amount claimed in the cost report and that a provider may challenge that action by raising a new claim before the PRRB. However, that interpretation of Section 1395*oo*(f)(1) would have the disfavored result of allowing a provider to seek judicial review of a claim that was never addressed on the merits by any adjudicatory body. See page 31 note 20, *infra*. In addition, the legislative history of the expedited judicial review provision makes clear that judicial review is available only in the event of a dispute between the provider and its intermediary. See H.R. Rep. 96-1167, 96th Cong., 2d Sess. 394 (1980) (emphasis added) ("[u]nder present law, a provider's *dissatisfaction with a particular determination made by its fiscal intermediary* on the basis of a regulation issued by the Secretary must first be brought to the Board, even though the Board may not have the authority to reverse or overrule the regulation. * * * [The statute] addresses this problem by giving medicare providers the right to obtain immediate judicial review in instances where the Board determines that it lacks jurisdiction to grant the relief sought").

Rep. 96-1167, 96th Cong., 2d Sess. 394 (1980)), the prerequisite for expedited review—consideration of a claim by the intermediary—must also be a prerequisite for Board action.[11]

The language in Section 1395*oo*(f)(1) is therefore highly probative of the meaning of the dissatisfaction requirement in Section 1395*oo*(a)(1)(A)(i): in each case further review is available only if the claim was first raised before the intermediary. Cf. *Japan Whaling Ass'n* v. *American Cetacean Society*, No. 85-954 (June 30, 1986), slip op. 14, 16-17 (relying on subsequent amendment as an aid in interpreting language in prior statute).[12]

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[11] Relying upon *Tallahassee Memorial Regional Medical Center* v. *Bowen*, 815 F.2d 1435 (11th Cir. 1987), petition for cert. pending, No. 87-830, petitioners contend (Br. 22-23) that Section 1395*oo*(f)(1) supports their interpretation of Section 1395*oo*(a)(1)(A)(i). The court of appeals in that case concluded that a provider that failed to present to its intermediary a claim based upon a challenge to a reimbursement regulation could obtain expedited judicial review with respect to that claim; the court found that such a claim satisfied the requirements of Section 1395*oo*(a)(1)(A)(i) and that the provider was therefore entitled to expedited judicial review (see 815 F.2d at 1461). The court of appeals' conclusion is based upon two fundamental errors. First, the court of appeals ignored the fact that expedited judicial review is available only with respect to an "action of the fiscal intermediary"; review cannot be had under this provision where the claim was never presented to the intermediary (see page 15 & note 10, *supra*). Second, as we have discussed (at 11-12), Section 1395*oo*(a)(1)(A)(i) does not authorize a provider to invoke the Board's jurisdiction with respect to a claim not previously presented to the provider's intermediary.

[12] Petitioners contend (Br. 17-18) that the passage of the statute stating that a provider that satisfies the jurisdictional requirements "may obtain a hearing with respect to such cost report" (42 U.S.C. (& Supp. III) 1395*oo*(a)) indicates that the hearing before the Board "concerns the cost report as a whole." In the first place, the scope of the hearing before the Board is a matter separate from the prerequisites for invoking the Board's jurisdiction. More importantly, Congress's reference to the "cost report" is undoubtedly a shorthand

b. The courts of appeals have frequently referred to Section 1395*oo*(d), the provision of the statute setting forth the Board's remedial powers, in ascertaining the circumstances under which a provider may invoke the Board's jurisdiction. See, *e.g.*, *Adams House Health Care* v. *Heckler*, 817 F.2d 587, 594 (9th Cir. 1987), petition for cert. pending, No. 87-443; *Athens Community Hospital* v. *Schweiker*, 743 F.2d at 8-9. This approach, however, ignores the fundamental distinction between the power of a provider to invoke the jurisdiction of the Board (the subject of Section 1395*oo*(a)) and the power of the Board once its jurisdiction has been invoked (the subject of Section 1395*oo*(d)). Like petitioners (Br. 14), we believe that these two issues are distinct, and that the scope of the Board's remedial powers in a case in which the relevant jurisdictional requirements have been satisfied is of little relevance in defining the content of those jurisdictional requirements. To the extent it is relevant, however, Section 1395*oo*(d) supports the construction of the statute for which we contend.

Section 1395*oo*(d) grants to the Board "the power to affirm, modify or reverse a final determination of the fiscal intermediary with respect to a cost report," and empowers the Board to "make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making [its] final determination" (42 U.S.C. 1395*oo*(d)). Congress made two separate grants of remedial authority in this subsection because the two grants serve different purposes. The first

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way of referring to reimbursement claims contained in the cost report. Congress would simply have had no reason to authorize the Board to conduct a hearing with respect to costs contained in the cost report for which the provider did *not* claim reimbursement; its intent was limited to providing for review of claims that were raised before the intermediary. See pages 22-25, 27-28 note 16, *infra*.

category—"the power to affirm, modify, or reverse a final determination of the fiscal intermediary"—mirrors the scope of the Board's jurisdiction. Just as the Board's jurisdiction may be invoked when a provider seeks review of an intermediary determination, the Board is endowed with the power to "affirm, modify, or reverse" that determination. If the existence of a prior intermediary determination were irrelevant to the Board's jurisdiction, there would have been no reason for Congress to single out this component of the Board's remedial power. Congress could simply have authorized the Board to act with regard to all "matters covered by [a] cost report."

The second, more general grant of remedial authority gives the Board leeway to act with respect to matters not addressed by the intermediary when, in a case properly before it, the Board in the exercise of its discretion deems such action appropriate. Thus, in describing the Board's remedial power, Congress stated that "[b]ased upon examination of all of the evidence, the [Board] may find in whole or in part for the provider or for the Government (*including a finding based upon the evidence before it that the provider owes sums in addition to the amount raised in the appeal*)" (H.R. Rep. 92-231, 92d Cong., 1st Sess. 108-109 (1971) (emphasis added)). This authority is likely to be most frequently invoked to allow

> the PRRB to revise aspects of the reimbursement calculation not actually contested by the provider, and possibly not considered by the intermediary (because not claimed for reimbursement by the provider), when such revision is necessary to accommodate other PRRB revisions of matters that were claimed by the provider, decided adversely by the intermediary, and then contested by the provider to the PRRB.

Athens Community Hospital, Inc. v. *Schweiker*, 743 F.2d at 9; see also *North Broward Hospital District* v. *Bowen*, 808 F.2d at 1409; *Community Hospital* v. *Health & Human Services*, 770 F.2d at 1262.

The Secretary has gone further, however, stating that, in an appropriate case, this discretionary authority may also be invoked with respect to matters unrelated to the issues raised by the provider before its intermediary. In *University Park Convalescent Center* v. *Aetna Life and Casualty Co.*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 30,993 (HCFA 1981), for example, the provider challenged the intermediary's treatment of certain costs incurred in connection with a capital expenditure. The Secretary's designee found against the provider with respect to its claim; he further stated that the evidence before the Board concerning that this issue indicated that the provider's physical plant had been purchased from corporations owned by the provider's relatives. Observing that "[t]his purchase appears to have a significant effect on the amount of Medicare reimbursement," the Secretary's designee concluded that "further inquiry into this transaction would be in order to determine whether reimbursement should be limited pursuant to the related-organization principle" and remanded the matter to the Board (*id.* at 10105). In other words, because the evidence before the Board had revealed a potentially serious error in the reimbursement determination, the Board had the power to consider that error and to modify the intermediary's award if that course of action proved appropriate, even though the particular reimbursement issue had not been raised before the intermediary. See also page 35, *infra*.

The Board's discretionary remedial authority provides no support for petitioners' contention that a provider has a right to a hearing before the Board with regard to claims not raised before the intermediary. First, the provider's right to invoke the Board's jurisdiction is set forth in Section 1395*oo*(a)(1)(A)(i), not Section 1395*oo*(d). A provider

may obtain discretionary relief from the Board only if he first satisfies the requirements of Section 1395*oo*(a)(1)(A)(i)—and one of those requirements limits the provider's right to Board review to issues that were raised before the intermediary.

Second, even when all of the requirements of Section 1395*oo*(a)(1)(A)(i) have been satisfied and a case is properly before the Board, the provider cannot compel the Board to make revisions in the intermediary's reimbursement award with respect to matters not raised before the intermediary because the Board's authority to act with respect to such issues is discretionary. Congress provided that the Board "shall have the power" to make such revisions, but did not direct that this authority be exercised in any particular manner. See *St. Luke's Hospital* v. *Secretary of Health and Human Services*, 810 F.2d at 327; compare 28 U.S.C. 2106 (grant of remedial authority to federal appellate courts); see also page 30 note 20, *infra*. Due to the complete absence of any standards restricting the Board's discretion in exercising this residual remedial authority, the Board's decision whether to exercise that authority is not subject to judicial review. See 5 U.S.C. 701(a)(2) (no judicial review of "agency action • • • committed to agency discretion by law"); *Heckler* v. *Chaney*, 470 U.S. 821, 830 (1985) (Section 701(a)(2) bars review "if the statute is drawn so that a court would have no meaningful standard against which to judge the agency's exercise of discretion").

In any event, the scope of the Board's discretionary remedial authority, and the reviewability of the Board's decisions with regard to the exercise of that authority, are not at issue in the present case. Petitioners have failed to satisfy the threshold requirements for Board jurisdiction

set forth in Section 1395*oo*(a)(1)(A)(i)—they did not have a case that was properly before the Board because they did not seek Board review of a matter raised before their intermediaries.[13]

2. The Legislative History of Section 1395*oo* Confirms the Limited Nature of a Provider's Right to Invoke the Board's Jurisdiction

The Provider Reimbursement Review Board was not part of the administrative structure created by the original Medicare statute. That statute simply directed the Secretary to "periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it" and to pay to the provider "the amounts so determined." Pub. L. No. 89-97, § 102(a), 79 Stat. 297, codified, as amended, at 42 U.S.C. (& Supp. III) 1395g. A provider that "wishe[d] to have [Medicare] payments • • • made through a national, State, or other public or private agency or organization," such as a private insurance company, could nominate an agency or organization for that purpose; the Secretary was authorized to "enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to such review by the Secretary as may be provided for by the agreement) of the amount of the [Medicare] payments required • • • to be made to such providers, and for the making of such payments by such agency or organization to such providers." Pub. L. No. 89-97, § 102(a), 79 Stat. 297, codified, as amended, at 42 U.S.C. (& Supp. III) 1395h. The statute contained no provision for administrative or judicial review of these reimbursement determinations. Cf. *Schweiker* v. *McClure*, 456 U.S. 188 (1982); *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982) (describing absence of administrative or judicial review of claims under "Part B" of Medicare).

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[13] Petitioners sought to raise before the Board only a single issue—the claim regarding reimbursement for medical malpractice insurance costs that they failed to present to their intermediaries.

Congress emphasized the "considerable role for the participation of private organizations in the administration of [the Medicare program]." H.R. Rep. 213, 89th Cong., 1st Sess. 45 (1965); see also S. Rep. 404, 89th Cong., 1st Sess. Pt. 1, at 52 (1965). It anticipated that most providers would nominate a private organization to "serve as a fiscal intermediary between themselves and the Federal Government"; the intermediary would enter into an agreement with the Secretary pursuant to which it would "determine the amount of payments due upon presentation of provider bills and make the payments" (H.R. Rep. 213, *supra*, at 45). The Secretary was authorized to delegate other administrative duties to intermediaries such as "providing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise to qualify as providers of services, serving as a center for communicating with providers, making audits of provider records, and performing related functions." *Ibid.*; see also S. Rep. 404, *supra*, at 52.

During the congressional hearings held prior to the adoption of the 1972 amendments to the Medicare statute, a number of provider representatives complained of the arbitrariness of intermediary determinations and voiced dissatisfaction about the lack of administrative and judicial review. Representatives of the Federation of American Hospitals testified that the statute "contains no provisions for administrative recourse by providers from the decisions of intermediaries"; they stated that "this is one of those rare instances in our Anglo-Saxon tradition where a party with a grievance has no recourse from a decision of the interested party on the other side of the controversy." *Medicare and Medicaid: Hearings Before the Subcomm. on Medicare-Medicaid of the Senate Comm. on Finance* 91st Cong., 2d Sess. Pt. 2, at 432 (1970). The Federation representatives also asserted that hearings held by intermediaries were "partial and limited,"

and that "[c]onflicting interpretations by different intermediaries remain[ed] unresolved" due to the absence of a "national appeals mechanism" (*ibid.*). Testimony by other groups representing providers' interests was to the same effect. *Id.* at 557, 622-628 (statements of various provider representatives); see also *Social Security and Welfare Proposals: Hearings Before the House Comm. on Ways and Means*, 91st Cong., 2d Sess. Pt. 4, at 1062, 1071, 1149, 1152, 1180 (1970) (same); *Social Security Amendments of 1970: Hearings Before the Senate Comm. on Finance on H.R. 17550*, 91st Cong., 2d Sess. Pt. 3, at 967-968, 972 (1970) (statement of Dr. Martin Steinberg, American Hospital Association); *Social Security Amendments of 1971: Hearings Before the Senate Comm. on Finance on H.R. 1*, 92d Cong., 1st and 2d Sess. Pt. 5, at 2285 (1972) (statement of Richard M. Loughery, American Hospital Association).

The congressional committee reports describing the provision of the 1972 amendments that established the Provider Reimbursement Review Board stated that "[u]nder present law there is no specific provision for an appeal by a provider of services of a fiscal intermediary's final reasonable cost determination." H.R. Rep. 92-231, 92d Cong., 1st Sess. 108 (1971); see also S. Rep. 92-1230, 92d Cong., 2d Sess. 248 (1972). The committees recognized that "HEW has developed administrative procedures to assist providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items," but concluded "that it is desirable to prescribe in law a specific procedure for settling disputed final determinations applying to the amount of program reimbursement." H.R. Rep. 92-231, *supra*, at 108; See also S. Rep. 92-1230, *supra*, at 248-249. In describing the Board's authority, Congress stated that a provider that filed a timely cost report could "appeal [to the Board] an adverse final decision of the fiscal intermediary" with respect to the period covered by the cost report. H.R. Rep. 92-231, *supra*, at 108; see also S. Rep. 92-1230, *supra*, at 248.

The 1972 amendments did not create an action for judicial review of the Board's reimbursement determinations. A provider was entitled to judicial review only if the Secretary reversed the Board's determination. See Pub. L. No. 92-603, § 243(a), 86 Stat. 1420. Two years later, Congress provided for review of all Board decisions and of decisions of the Secretary affirming a Board determination. See Pub. L. No. 93-484, § 3(a), 88 Stat. 1459. Finally, Congress in 1980 completed the judicial review structure by adding the expedited judicial review provision. See page 15, *supra*.

The evolution of the Medicare statute, together with the legislative history specifically addressing the powers of the PRRB, make clear that a provider may invoke the Board's jurisdiction only with respect to a claim previously raised before the provider's intermediary. An administrative structure for evaluating reimbursement claims—the intermediary system—was already in place when Congress established the PRRB. Providers necessarily presented all reimbursement claims to their intermediaries, because the intermediaries had sole responsibility for making reimbursement determinations. Nothing in the statutory language or legislative history indicates that Congress intended to displace the preexisting responsibility of intermediaries to hear and determine all reimbursement claims in the first instance. The Board was instead created in response to providers' complaints about the unfairness of intermediaries' determinations and their requests for an impartial review panel. It was placed atop the existing administrative structure to serve as an appellate body to referee disputes between providers and their intermediaries. Petitioner's claim that a provider may require the Board to make reimbursement determinations on a de novo basis is squarely inconsistent with Congress's conception of the Board as an appellate tribunal whose role is to review intermediary determinations.

Petitioners contend (Br. 16, 27) that Congress, in creating the PRRB in 1972, did not intend to require presentation of a reimbursement claim to the intermediary in a case in which the claim is based upon a challenge to a reimbursement regulation. But nothing in the legislative history of the statute establishing the PRRB indicates that Congress intended to change the preexisting practice of presenting all reimbursement claims to the intermediary. Moreover, despite the fact that the PRRB, like the intermediary, has no authority to overturn a regulation issued by the Secretary (see 42 C.F.R. 405.1867 (1987)), Congress initially required all providers to go through a Board hearing concerning reimbursement claims even if the only issue presented was a regulatory challenge that the Board could not resolve. That requirement was eliminated only upon the adoption of the expedited judicial review provision in 1980. Since Congress prior to 1980 did not distinguish between claims resting upon challenges to regulations and all other claims, there is no basis for assuming that Congress in 1972 intended to exempt such claims from the general rule regarding the presentation of claims to the intermediary. To the contrary, Congress expressly reaffirmed, in the express language of the expedited judicial review provision, the requirement that such claims be presented to the intermediary. See page 15, *supra*. In sum, the legislative history strongly reinforces the conclusion that a provider is entitled to a Board hearing only with respect to reimbursement claims raised before the intermediary.

3. The Secretary's Interpretation of Section 1395*oo* Should be Upheld Because It is Reasonable

In any event, the Secretary's determination that a provider may seek review only of claims initially presented to the intermediary should be upheld because it is " 'based on

a permissible construction of the statute.' " *NLRB* v. *United Food & Commercial Workers Union*, No. 86-594 (Dec. 14, 1987), slip op. 10 (quoting, *Chevron U.S.A. Inc.* v. *NRDC*, 467 U.S. 837, 843 (1984)).[14]

a. The Secretary's interpretation of the statute furthers important policies of finality and administrative efficiency. Approximately 15,000 providers participate in the Medicare cost reimbursement process; each provider must file an annual cost report that is several hundred pages in length. The Secretary is responsible for reviewing these claims and determining the amount of reimbursement owed to each provider in as timely and efficient a manner as possible while maintaining the level of accuracy necessary to protect the public fisc against improper claims.[15] The primary responsibility for reviewing a provider's cost report and determining the amount of reimbursement owed to the provider lies with the fiscal intermediary. Indeed, prior to the creation of the PRRB, the intermediary had sole responsibility for this task. See pages 21-22, *supra*.

The vast undertaking of processing and reviewing these claims for reimbursement can be performed efficiently only if providers are required to include all of their reimbursement claims in the cost reports that trigger the reim-

[14] Petitioners suggest (Br. 24) that deference to the Secretary's interpretation is not appropriate because the question in this case involves "the relationship of the agency to the federal courts." But the question here concerns only what steps must be taken by a provider to secure review – the Secretary has not attempted to confine or restrict the right of judicial review. The substance of the issue involves the allocation of decisional responsibility within the agency itself, surely a subject upon which the agency's views are entitled to special weight.

[15] Providers obviously have a considerable interest in the timely processing of reimbursement claims. Cf. *Bowen* v. *City of New York*, No. 84-1923 (June 2, 1986), slip op. 13 (noting the interest of program beneficiaries in the efficient processing of claims).

bursement process. Because the intermediary is responsible for evaluating all of the reimbursement claims included in the cost report, the provider's reimbursement claims can thus be comprehensively considered. Accordingly, where several reimbursement claims involve similar aspects of a provider's operations or necessitate the application of the same accounting or legal principles, the intermediary would be able to treat the issues together, thus eliminating redundant effort and ensuring internally consistent results.

Permitting the provider to raise new reimbursement claims before the Board would require the Board to duplicate the intermediary's efforts by examining a portion of the cost report that was likely reviewed by the intermediary in connection with other reimbursement claims. In addition, the Board would be required to devote its limited resources to a matter that might well have been resolved by the intermediary had the provider raised the claim in its cost report. That, in turn, would distract the Board's attention from its principal responsibility – resolving disputes between providers and their intermediaries. Permitting the provider to revise its claim after the intermediary's issuance of the Notice of Program Reimbursement would therefore " 'make the PRRB the tribunal of original jurisdiction, eliminating a tier of review, and [have the effect of] possibly substantially slowing the reimbursement process for other providers.' " *Athens Community Hospital, Inc.*, 743 F.2d at 6-7 (citation omitted); see also *North Broward Hospital District* v. *Bowen*, 808 F.2d at 1409; cf. *Thomas* v. *Arn*, 474 U.S. 140, 146-148 (1985) (applying similar rationale to uphold a rule making the filing of objections in the district court a prerequisite to appealing a magistrate's determination to the court of appeals).[16]

[16] Petitioners assert (Br. 32-33) that Congress intended the Board to be a tribunal of original jurisdiction. While the Board does have authority to gather new evidence on the matters brought before it (see 42 U.S.C. (& Supp. III) 1395*oo*(a), (c)), the legislative history makes clear that the Board was not to conduct a de novo review of all of the prior

The Secretary's approach also protects the integrity of the cost reimbursement process. Allowing providers to assert new reimbursement claims before the Board gives providers the opportunity of utilizing two completely different reimbursement strategies—one strategy directed toward the intermediary and one directed toward the Board and the courts. The provider could first allocate its costs in a manner that could be upheld on the basis of favorable rulings by the intermediary; if that strategy was not successful, the provider could adopt an entirely new approach, such as challenging the validity of the regulations governing various reimbursement determinations. Strategic maneuvers of this sort have no place in an administrative process that must be efficient if it is to be effective. The Secretary's interpretation of the statute requires a provider to "present a coherent claim for reimbursement at the time it files its cost report"; the provider may not "present claims to its intermediary, await the intermediary's decision, and then decide based upon its success before the intermediary whether to raise additional claims before the Board." *Baptist Hospital East* v. *Secretary of Health and Human Services*, 802 F.2d 860, 865 (6th Cir. 1986); see also *Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d at 6.[17]

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determinations. The hearing before the Board is limited to the issues upon which the provider and the intermediary disagree. Indeed, the genesis of the Board's power to conduct such a hearing was most likely providers' complaints that the hearings conducted by intermediaries were biased because the intermediary had already taken a position contrary to the provider. See pages 22-23, *supra*.

[17] Petitioners suggest (Br. 33-36) that a provider could not engage in this conduct because the provider must fill out the cost report in accordance with the applicable regulations and the intermediary will simply disallow any improperly-claimed costs. Contrary to petitioners' apparent view, however, submitting information on cost reports is not a wholly mechanical process. Accounting and legal judgments come into play in determining the proper allocation of costs. A provider plainly has sufficient leeway to engage in behavior of the sort described in the text.

Requiring that claims be raised before the intermediary in the first instance also ensures that the Board will have the benefit of the intermediary's expert assessment of the provider's claim. One of the principles underlying the doctrine of exhaustion of administrative remedies is that, because "agency decisions are frequently of a discretionary nature or frequently require expertise, the agency should be given the first chance to exercise that discretion or to apply that expertise" (*McKart* v. *United States*, 395 U.S. 185, 194 (1969)). Fiscal intermediaries have considerable expertise in the application of the cost reimbursement rules. Most intermediaries are private insurance companies well versed in the application of reimbursement principles to medical institutions. And, because they apply the Medicare reimbursement rules on a daily basis, intermediaries are familiar with the particular requirements of those rules. In addition, the intermediary may have gained familiarity with the provider's operations and accounting techniques by virtue of its review of past cost reports. The Secretary's conclusion that the Board is entitled to the benefit of that expertise is plainly reasonable.[18]

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[18] Petitioners repeatedly attempt to deprecate the importance of the intermediary's role in the cost reimbursement process, characterizing the intermediary as a "government contractor" (Br. 22), asserting (Br. 32-33) that the cost report is "simply an accounting document" and suggesting that "[t]he intermediary's job is to audit that document in an accounting sense, not to act as a tribunal." Although the cost report is an accounting document in the sense that it presents a breakdown of the provider's costs, the intermediary must determine whether the provider correctly allocated its costs in the manner required by the Medicare cost reimbursement rules. The proper application of those rules frequently involves discretion and judgment, and those determinations, which formerly were the intermediary's alone, are now committed to the intermediary in the first instance. Indeed, the legislative materials relating to the adoption of the original Medicare Act are replete with references to the importance of the intermediary's role in the cost reimbursement process. See page 21-22, *supra*.

Petitioners also state (Br. 32) that the Board will not be deprived of the intermediary's expertise with respect to claims presented to the

Finally, the Secretary's interpretation of the statute imposes no significant burden upon providers. Every provider must file a cost report in order to obtain reimbursement under the Medicare program. The Secretary's construction of the statute simply requires that the provider include all of its reimbursement claims in the report. And this requirement does not set a trap for the unwary. Unlike other provisions of the social security laws that affect individual citizens who lack the sophistication or the access to legal services needed to identify and comply with strict procedural rules, the Secretary's interpretation of the statute at issue here affects health care providers that are sizeable businesses. These institutions already are required to devote substantial resources to compliance with the Medicare statute. Those existing compliance mechanisms can easily be adapted to ensure that the institution claims all of its costs in its cost report.[19]

Board in the first instance because the intermediary appears as a party in proceedings before the Board. But the intermediary's participation will be hampered by the fact that it was unable to consider the question at the time it evaluated the cost report and therefore could not obtain relevant background information from the provider.

[19] The court in *St. Luke's Hospital* v. *Secretary of Health and Human Services*, *supra*, analogized the Board to other types of appellate tribunals and concluded that, like those other tribunals, the Board is endowed with the discretion to hear claims not presented below (see 810 F.2d at 330). The flaw in this analogy is that it ignores the fact that Congress did not intend to create a general appellate tribunal; it established the Board specifically to consider disputes between providers and intermediaries. In addition, the appropriate scope of a provider's right to invoke the Board's jurisdiction must be evaluated with reference to the enormous administrative task of performing reimbursement determinations and the relatively sophisticated nature of the parties seeking reimbursement. In these circumstances the Secretary reasonably concluded that strict procedural rules best comport with the congressional mandate to establish an efficient system for the calculation of the amount of reimbursement owed to providers.

b. Petitioners nevertheless contend that a provider should not be required to raise before its intermediary a reimbursement claim that the intermediary lacks the authority to grant. As an initial matter, we note that the statute draws no distinction between claims that the intermediary may rule upon and those which it may not. To the contrary, in amending Section 1395*oo* to provide for expedited judicial review of reimbursement claims that are dependent upon "a question of law or regulations" (42 U.S.C. (& Supp. III) 1395*oo*(*f*)(1)), Congress expressly required presentation of the matter to the intermediary, even though the intermediary lacks the authority to rule on such matters (see page 15, *supra*).[20]

Moreover, the PRBB is subject to the same constraint as an intermediary—it cannot overturn regulations. Yet, prior to the creation of the right to expedited judicial review, such claims had to be heard by the Board; indeed, the whole rationale for the expedited review provision was that it would allow providers to avoid the formality of a Board hearing concerning such claims. The mere fact that the intermediary lacks authority to award reimbursement on the ground claimed by the provider accordingly does not provide a basis for distinguishing between those situations in which a claim must be raised before the intermediary and those in which it need not.

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[20] Indeed, the structure of the expedited review provision makes clear that such claims must be raised before the intermediary. When a provider files a request seeking a determination by the Board with respect to its authority to consider the provider's claim, the Board must act on the request within 30 days (42 U.S.C. (& Supp. III) 1395*oo*(*f*)(1)). That relatively brief period is plainly insufficient to allow the Board to undertake a thorough review to determine in the first instance whether "[the Board] is without authority to decide the question" (*ibid.*). The Board must make use of the the intermediary's evaluation of that question. See page 32, *infra*. With respect to this type of claim, therefore, it is clear that Congress intended that the matter be raised before the intermediary.

Furthermore, the policies that support the general requirement that claims be raised before the intermediary also support the imposition of that requirement in the present context. This Court has recognized that even where an administrative tribunal lacks authority to grant the relief sought by a party, the agency should nevertheless be allowed to determine whether the claim does in fact turn upon the challenge to the governing regulation or statute, as well as whether the claim is otherwise invalid or cognizable under a different statutory or regulatory provision. See *Heckler* v. *Ringer*, 466 U.S. 602, 618-620 & n.12, 623-624 (1984); *Weinberger* v. *Salfi*, 422 U.S. 749, 765 (1975). Here, the intermediary might find a provider's claim barred for a reason other than the standard contained in the regulation challenged by the provider. Alternatively, the intermediary could find that the provider was entitled to the claimed reimbursement on grounds that render the challenge to the regulation moot. Cf. *Heckler* v. *Ringer*, 466 U.S. at 619-620 n.12. Finally, consideration of these claims by the intermediary is useful to the Secretary's overall administration of the Medicare program. Intermediaries have suggested changes in cost reimbursement rules on the basis of experience gained in considering challenges to those rules.[21]

Apart from their contention that the Secretary's interpretation of the statute is not reasonable, petitioners also assert (Br. 37-41) that deference to the Secretary's interpretation of the statute is inappropriate because that interpretation is not embodied in a regulation, was not

[21] Petitioners contend (Br. 30-31) that the reasons underlying Congress's decision to allow providers to avoid PRRB review of claims based upon regulatory challenges are equally applicable here. What petitioners ignore is that, unlike a PRRB hearing, the cost report is not issue specific; every provider must file a cost report that is then evaluated by a fiscal intermediary. Since the cost report must be filed in any event, it is logical to require a provider to include all of its reimbursement claims in that document.

developed at the time of the enactment of the statute, has not been consistently adhered to, and is tainted by the Secretary's alleged hostility to judicial review. None of these arguments provides any basis for discounting the deference accorded to the Secretary's construction of the statute.

First, contrary to petitioners' apparent belief, an administrative agency's interpretation of a statute need not be embodied in a regulation in order to be entitled to deference. Where, as here, the agency construes the statute it is charged with administering in the course of an adjudicatory proceeding, the agency's determination is also entitled to deference. See, *e.g.*, *Fall River Dyeing & Finishing Corp.* v. *NLRB*, No. 85-1208 (June 1, 1987), slip op. 14. In fact, the Secretary's interpretation at issue here is set out in the Medicare Provider Reimbursement Manual, a publication issued by the Secretary as a guide for Medicare providers. The manual states that "[p]roviders are permitted to dispute regulatory and policy interpretations through the appeals process established by the Social Security Act. The provider must include the nonallowable item in the cost report in order to establish an appeal issue" (2 Medicare and Medicaid Guide (CCH) ¶ 9115).[22]

[22] The provision quoted in the text is the current version, which was issued in July 1981. The prior version of the provision, dated September 1980, states (Medicare Provider Reimbursement Manual, Part II-Provider Cost Reporting Forms and Instructions, Transmittal No. 4):

> Providers that include nonallowable cost on a cost report may do so where the cost report item has been disputed and the provider clearly discloses this particular item is being included in the cost report only to establish the basis for an appeal. Nonallowable cost items may have been determined from the intermediary audit or desk review of the provider's prior year cost report or from provider adjustments to the cost report which are supported by decisions of the intermediary's hearing officer or the Provider Reimbursement Review Board, even though such decisions have been subsequently overruled by the Administrator.

The manual provision is essentially a codification of the rule applied by the Secretary and the Board in individual reimbursement decisions.[23]

Second, although petitioners are correct that the Secretary did not address the present issue at the time of the establishment of the PRRB, that fact is of little moment in the circumstances of this case. As we have discussed, the PRRB was placed atop a preexisting administrative process under which intermediaries were afforded complete responsibility for the determination of providers' reimbursement claims. Since, of necessity, all claims were presented to the intermediary under the old system, it would have been quite logical to assume that intermediaries would continue to consider all claims in the new system. When cases came before the Board in which providers failed to present claims to their intermediary, the Board, and then the Secretary, adopted the interpretation of the statute that is at issue in this case. In these circumstances, the fact that the Secretary's interpretation of the statute was not adopted at the time of the statute's enactment does not justify a reduction in the weight accorded the Secretary's interpretation.

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[23] See, *e.g.*, *LAC Weighted Ancillary Group Appeal* v. *Blue Cross and Blue Shield Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 34,866, at 9323 (PRRB 1985); *Virginia Hospital Labor and Delivery Room Days Appeal Group* v. *Blue Cross and Blue Shield Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 33,517, at 9524 (HCFA 1983); *Mt. Zion Hospital-Hill Burton Group Appeal* v. *Blue Cross and Blue Shield Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 32,370, at 9840-9841 (PRRB 1982); *Sacramento-Sierra Hospital Group Appeal* v. *Blue Cross Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 31,701, at 10255 (PRRB 1982); *American Hospital Ass'n Group Appeal* v. *Blue Cross Ass'n* [New Developments] Medicare & Medicaid Guide (CCH) ¶ 30,786, at 9409-9411 (HCFA 1980); PRRB Decision No. 77-D61, [New Developments] Medicare & Medicaid Guide ¶ 28,657, at 10289-10290, 10291 (1977) aff'd, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 28,698, at 10453-10454 (HCFA 1977); see also *Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d at 8 & n.12 (collecting cases).

Third, petitioners argue that the Secretary's interpretation of the statute has been inconsistent, citing four Board decisions that assertedly conflict with the Board's decision in the present case. But the decisions cited by petitioners are not inconsistent with the Secretary's present position in this case. As petitioners themselves recognize (Br. 13-14), there is a difference between a provider's right to invoke the Board's jurisdiction and the scope of the Board's remedial authority in a case that is properly before it. The present case involves the former question, while the allegedly inconsistent decisions all involve the latter issue.[24] The Secretary has in fact maintained a single con-

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[24] In *Unity Hospital* v. *Blue Cross Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 31,097 (PRRB 1981), for example, the Board found that, because the provider's cost report was "properly before the Board" without considering an issue the provider failed to raise in its cost report, the Board could utilize its residual authority under Section 1395*oo*(d) to consider that issue in the first instance (¶ 31,097, at 10407). The Board distinguished *American Hospital Ass'n* v. *Blue Cross Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 30,786 (HCFA 1980), in which the Board was found to lack jurisdiction over a claim not raised before the intermediary, on the ground that "the jurisdiction question [in *American Hospital Ass'n*] dealt with a provider who did not have a cost report properly before the Board" (¶ 31,097 at 10407).

Thus, because the provider in *Unity Hospital* had a right to Board review with respect to an issue raised before the intermediary, the Board had jurisdiction over the case and could exercise its discretionary authority to consider an issue not raised before the intermediary. The other decisions cited by petitioners are to the same effect. *Ravenswood Hospital Medical Center* v. *Blue Cross Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 31,945, at 9608 (PRRB 1982); *St. Joseph Medical Center* v. *Blue Cross Ass'n*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 30,925, at 9855-9856 (PRRB 1981); see also *University Park Convalescent Center* v. *Aetna Life & Casualty Co.*, [New Developments] Medicare & Medicaid Guide (CCH) ¶ 30,993 (HCFA 1981).

Petitioners argue (Br. 38-39) that *Charter Peachford Hospital, Inc.* v. *Bowen*, 803 F.2d 1541 (11th Cir. 1986), is another case in which the Board considered an issue not raised before the intermediary. The cost

sistent position with respect to a provider's right to invoke the Board's jurisdiction: the provider is entitled to a hearing before the Board only when it seeks review of an issue that was raised before its intermediary. After that jurisdictional requirement is satisfied the Board may, on its own motion, exercise its discretionary authority to consider issues not raised before the intermediary. Because of the absence of any inconsistency, there are no grounds for discounting the Secretary's interpretation of the statute.[25]

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report in that case was before the Board on several matters unrelated to the issue not raised before the intermediary. See *Charter Peachford Hospital* v. *Mutual of Omaha Ins. Co*, [New Developments] Medicare and Medicaid Guide (CCH) ¶ 34,102 (PRRB 1984). Accordingly, the Board's decision to exercise its residual discretionary jurisdiction falls in the same category as the decisions just discussed. Moreover, as the transcript of the Board hearing shows (see J.A. 64a-67a), the unraised issue was actually subsumed in an issue that was contested before the intermediary. In view of that "unusual" circumstance, the Board decided to exercise its discretionary authority to consider the unraised issue (*id.* at 67a).

[25] Even if the four Board decisions cited by petitioners did deviate from the Secretary's construction of the statute, they would be insufficient to discredit the many other decisions consistent with the ruling in this case. Especially in a program as vast as the Medicare program, more than a few stray decisions should be required before no deference can be accorded to the basic position asserted by the Secretary. This Court has observed that "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view" (*INS* v. *Cardoza-Fonseca*, No. 85-782 (Mar. 9, 1987), slip op. 25 n.30 (citation omitted)). The Court applied that principle in *Cardoza-Fonseca* on the basis of its conclusion that the agency had exhibited a "long pattern of erratic treatment" of the question of statutory interpretation presented in that case (*id.* at 25-26 n.30). Absent repeated, express shifts in position such as those present in *Cardoza-Fonseca*, however, there is no basis for discounting the Secretary's interpretation of the statute.

Fourth, petitioners cite no authority for their novel contention that no deference is due to the statutory interpretations of an agency whose interpretations have sometimes been rejected by the courts. It is the agency, not the courts, that is the entity chosen by Congress to administer the Medicare statute. The fact that some courts have disagreed with the Secretary's interpretation of the statute cannot by itself be sufficient to render the Secretary's position unreasonable. Any other result would dramatically reduce an agency's authority to construe the statutes it is charged with administering, thereby undercutting the important policies underlying the principle of judicial deference to agency action. See, *e.g.*, *Chevron U.S.A. Inc.* v. *NRDC*, 467 U.S. at 865-866.

In any event, petitioners suggest no standards to determine whether an agency's "batting average" in court is sufficiently high to warrant continued deference to its statutory constructions. We submit that any such standard would be inherently arbitrary, and would in effect constitute judicial second-guessing of Congress's decision to commit the administration of a statute to the agency's expertise.

Finally, the Secretary's position should not be discounted because of an alleged hostility to judicial review. The Secretary's various prior positions were quite reasonable in light of the fact that the governing statute made no provision for administrative or judicial review of intermediaries' determinations and, in fact, contained a provision precluding such review (see 42 U.S.C. (& Supp. III) 405(h)).[26] Indeed, the providers that petitioned Congress for the adoption of a statute permitting administrative and judicial review, as well as Congress itself, recognized that such review was not available under the

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[26] This provision is made applicable to the Medicare statute by 42 U.S.C. (& Supp. III) 1395ii.

Act. See pages 22-23, *supra*. And when Congress did create rights to judicial review, it did so on an incremental basis (see page 24, *supra*), thus providing further support for the Secretary's position that the original statute did not authorize wholesale judicial review.

In sum, the Secretary's settled interpretation of the statute—that a provider has a right to Board review only with respect to an issue raised before an intermediary—is reasonable and should be upheld by this Court.

4. Providers Had Notice That They Would Be Entitled To Invoke The Board's Jurisdiction Only With Respect To Reimbursement Claims Raised Before Their Intermediaries

Petitioners contend (Br. 44-46) that even if the Secretary has correctly interpreted the statute, the jurisdictional bar cannot be applied to them because the Secretary did not provide prior notice of the requirement that all reimbursement claims must be included in the cost report. Petitioners do not appear to assert that they failed to claim reimbursement on *their* cost reports because they had no notice that such a course of action was necessary; and no evidence of any such reliance was introduced before the PRRB. Moreover, any such claim would be highly suspect in view of the fact that the vast majority of providers did raise all of their reimbursement claims in their cost reports. In the present case, for example, 25 of the 27 providers that challenged the 1979 rule governing reimbursement for malpractice insurance costs had raised the issue on their cost reports. See also *Tallahassee Memorial Regional Medical Center* v. *Bowen*, 815 F.2d 1435, 1441 (11th Cir. 1987), petition for cert. pending, No. 87-380 (30 of 35 hospitals raised issue on their cost reports); *Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d at 10 (observing that 71 of 72 hospitals in a companion case claimed the disputed cost on their cost reports).

In any event, as we have discussed (at 11-38), the statute, legislative history, and administrative decisions provided ample notice of this requirement. Since all claims had to be presented to the intermediary prior to the creation of the PRRB, and neither Congress nor the Secretary altered that preexisting practice after the Board was created, providers had no grounds for concluding that circumvention of the intermediary had become permissible.[27] And the Secretary and the PRRB had held several times—prior to the filing of the cost reports at issue in this case—that a provider could not invoke the Board's jurisdiction with respect to a claim that was not raised before its intermediary. See page 34 note 23, *supra*. For these reasons, Medicare providers had more than sufficient notice of the Secretary's intepretation of the statute.

B. Even if the Board Has The Power to Hear A Case In Which A Provider Did Not Raise Its Claim Before The Intermediary, The Board May Exercise Discretion To Decline To Hear Such A Case

Even if the Court were to reject our submission and conclude that the Board's jurisdiction may be invoked by a claim not previously presented to the intermediary in the cost report, a provider would not necessarily be entitled to compel the Board to adjudicate such a claim in every case. We submit that the Board would have broad discretion to decline to hear such a claim, and that such discretion was properly exercised on the facts of this case.

The general rule in judicial proceedings is that an appellate court will not consider an issue raised for the first time on appeal. This general rule is justified by considera-

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[27] Indeed, as we have noted, the very portion of the statute upon which petitioners relied before the Board—the expedited judicial review provision—applies by its terms only to an "action" of the fiscal intermediary.

tions of judicial economy and the advantages of full consideration of the legal issues and development of the factual record in the trial court. The general rule is, of course, subject to exceptions for jurisdictional questions and situations where failure to hear the claim would result in exteme unfairness. *Hormel* v. *Helvering*, 312 U.S. 552, 557-559 (1941); *National Fidelity Life Insurance Co.* v. *Karaganis*, 811 F.2d 357, 360-361 (7th Cir. 1987); *District of Columbia* v. *Air Florida, Inc.*, 750 F.2d 1077, 1084-1085 (D.C. Cir. 1984); *In re Southland Supply, Inc.*, 657 F.2d 1076, 1079 (9th Cir. 1981).[28]

As we have discussed (at 26-32), substantially the same policy reasons weigh against the exercise of Board jurisdiction over claims that were not first presented to the intermediary. The PRRB should be free to exercise the same wide discretion in determining whether to consider a claim that was not raised before the intermediary. Indeed, the Board's discretion should, if anything, be broader than that exercised by a court. Unlike the typical situation in an appellate court, where a party seeks to raise a new legal argument justifying its prayer for relief in the lower court, a provider that raises a new reimbursement claim before the Board is seeking entirely new relief. The situation is

[28] This Court recently recognized these principles in upholding, as an exercise of a court's inherent supervisory power, a rule requiring a party to object to a magistrate's report before the district court in order to obtain review of those issues in the court of appeals. See *Thomas* v. *Arn*, 474 U.S. 140 (1985). The Court observed that this rule, "by precluding appellate review of any issue not contained in objections, prevents a litigant from 'sandbagging' the district judge by failing to object and then appealing" (*id.* at 147-148). The Court further stated that the rule prevented the "inefficient use of judicial resources" because, "[a]bsent such a rule, any issue before the magistrate would be a proper subject for appellate review. This would either force the court of appeals to consider claims that were never reviewed by the district court, or force the district court" to review every issue in the case (*id.* at 148).

akin to a tort action in which—after the case is on appeal—the plaintiff seeks to present new evidence showing a right to increased damages due to injuries that were not claimed in the trial court. For these reasons, the Board should have discretion to conclude that, as a general matter, it will not consider a reimbursement claim that was not raised before the intermediary and is instead advanced for the first time when the appeal is brought before the Board—even if the Court were to reject our primary submission that Congress has mandated that result.[29]

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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JANUARY 1988

[29] Petitioners assert (Br. 41-44) that the Board should not be allowed to exercise any discretion at all in deciding whether to hear claims not presented to the intermediary. They rely on the general policies in favor of reviewability of administrative action and against unreasonably narrow interpretations of waivers of sovereign immunity. Petitioners completely ignore the general discretion afforded to appellate tribunals to control their dockets and establish reasonable rules of procedure. Moreover, the policies cited by petitioners are entirely inapposite here. There is no preclusion of judicial review in the present case; the Secretary (or, under our principal submission, Congress) has simply established reasonable procedures that a provider must follow in order to avail itself of its rights to an administrative appeal and judicial review. Cf. *Thomas* v. *Arn*, 474 U.S. at 155.

* The Solicitor General is disqualified in this case.

ADDENDUM

42 U.S.C. (& Supp. III) 1395*oo* provides in pertinent part:

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if –

(1) such provider –

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A) or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

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(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

• • • • •

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the

provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District

Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

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In the Supreme Court of the United States

OCTOBER TERM, 1987

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THE DEACONESS HOSPITAL OF CINCINNATI, OHIO,
PETITIONERS,

v.

OTIS R. BOWEN, M.D., SECRETARY
OF HEALTH AND HUMAN SERVICES,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

REPLY BRIEF FOR THE PETITIONERS

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ARGUMENT

I. INTRODUCTION

The Secretary concedes that *Athens Community Hospital, Inc. v. Schweiker*, 743 F.2d 1 (D.C. Cir. 1984) ("Athen II"), *modifying* 686 F.2d 989 (D.C. Cir. 1982) ("Athen I"), was wrong in holding that 42 U.S.C. § 1395oo(d) (1982) controls the Board's jurisdiction, and he agrees that section 1395oo(a) (1982) is the governing statutory provision. Resp. Br. at 11. Nevertheless, the Secretary seizes upon fragments of the *Athens* analyses and attempts to apply them in the context of section 1395oo(a). Among the fragments of the *Athens* reasoning heavily relied upon by the Secretary are the notions that

the filing of the cost report is an adversary proceeding, that the intermediary resolves disputes in auditing the cost report, and that the PRRB is an appellate body. These are fundamental mischaracterizations of the administrative process, as we will demonstrate below.

A second concession by the Secretary completely undermines his interpretation of the statute and the alleged practical justifications for that interpretation. The Secretary acknowledges that a provider may raise a claim before an intermediary simply by "noting its disagreement with the policy or regulation governing the reimbursement issue." Resp. Br. at n.8. In such a circumstance, the provider fills out its cost report in accordance with the regulations and then attaches to the completed cost report a cover letter indicating it wishes to contest a particular regulation. The intermediary does not write an audit adjustment, and its audit of the cost report is exactly the same as for a self-disallowing hospital. The provider need not even provide the alternative amount of reimbursement it would receive. *See Athens II*, 743 F.2d at 5, 8 n.12.

Nonetheless, the Secretary finds this cover note sufficient for a provider to preserve its appeal rights. This process serves *none* of the exhaustion considerations put forth by the Secretary to justify his interpretations, and functionally is no different from the situation of the Hospitals here. If the Board accepts jurisdiction over providers based on the contents of a cover note, without an adjustment by the intermediary, there is no justifiable reason why the Board cannot assert jurisdiction over providers that self-disallow costs by complying with a regulation without the benefit of a cover note.

II. THE NATURE OF THE COST REPORTING PROCESS DOES NOT SUPPORT THE SECRETARY'S POSITION

The Secretary contends that the Hospitals should not be heard on their claim for self-disallowed costs where they have treated the malpractice premium costs in their cost

reports in a manner consistent with his regulation. The common base for his arguments is that the self-disallowance operates to avoid an implied or unstated adversary process in the cost reporting process in which the intermediary is both adversary and tribunal. This argument is woven throughout the Secretary's Brief more by suggestion, implication and legerdemain than by direct assertion. Not only is it the foundation for all of the Secretary's arguments focusing on the cost report audit process, it also is the *sine qua non* for his argument that requiring the PRRB to entertain appeals involving self-disallowed costs improperly forces the PRRB to act as the trial forum and denies it the appellate function. In fashioning these arguments the Secretary creates a house of cards.

A. Filing A Cost Report Is Not An Adversarial Process

The fundamental weakness in the Secretary's entire argument is that it rests upon a distorted characterization of the cost reporting process. The Secretary claims that when his contract agent, the intermediary, receives a cost report submitted by a provider and then audits that cost report to assure that only those costs permitted under the Secretary's regulations, instructions and policies are reimbursed, the intermediary is *not* performing an audit function as required by the statute, regulations, manual instructions and intermediary contract. Rather, the Secretary claims, the intermediary is acting both as adversary and as a tribunal in an adversary proceeding. This position not only flies in the face of common sense, it is contrary to the regulatory scheme and the contract under which the intermediary operates.

First, it should be noted that the intermediary's job in auditing a provider's cost report is to verify and audit documentation of the costs included in the cost report as

to whether such costs were actually incurred in providing covered services, and the nature and amount of such costs. In addition, the intermediary determines whether the provider has properly classified such costs as to the services provided and then properly apportioned those costs between Medicare and non-Medicare functions.[1] Pursuant to their contracts, the intermediaries perform these tasks through the application of the Secretary's regulations, rulings, manual instructions and policies. When a cost is not addressed by a specific written directive such as a manual instruction, the intermediaries are instructed to use generally accepted accounting principles to account for the cost. (Provider Reimbursement Manual, Forward).

If either the amount of actual cost has been incorrectly submitted or the calculation of the Medicare program's share of the cost is not in accordance with regulations (the substantive issue in this case), then the intermediary is required to make correcting adjustments in the cost report. Otherwise, the intermediary takes no action other than to pay Medicare's share as calculated under the regulation.

Except with respect to costs that are not addressed by written pronouncements from the Secretary or by generally accepted accounting principles, or with respect to the characterization of costs that may fall into more than one category or classification, the intermediary has *no* discretion in how costs in a cost report are to be treated. This case does *not* involve the cost report treatment of any costs with respect to which the intermediary has any discretion. It involves the apportionment of malpractice premium costs which is definitively controlled by a regulatory formula which the intermediary is absolutely bound to apply.

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[1] Since the Hospitals' malpractice premium costs were included in the cost report, the intermediary did verify the nature, amount, classification and apportionment of these costs during its audit for purposes of payment under the discredited 1979 Malpractice Rule.

Simply put, the intermediary's hands are tied in that it can only apply the regulations and instructions to costs that are in the cost report. Where an instruction or a regulation (such as the Malpractice Rule) results in what a provider perceives as underpayment with respect to Medicare's share, contrary to the Secretary's suggestion (Resp. Br. at 10-11) there is no dispute with the intermediary. The dispute is with the Secretary and his policies as implemented by regulation or instruction. In that context, to say, as the Secretary does, that no dispute can arise unless the provider demands from the intermediary what the Secretary has forbidden the intermediary to give, creates the false illusion that somehow the intermediary could give relief in the case of disputes over reimbursement amounts that are mandated by regulation.

In contrast to the Secretary's suggestion (Resp. Br. at n. 10), the intermediary's audit of the provider's cost report pursuant to regulations is not an adjudication; it is nothing more than an audit to assure compliance with the applicable regulations. The intermediary is not an adversary and does not sit as an adjudicatory body any more than are auditors doing a reconciliation for the final payment under any government cost contract.

The notion that the intermediary is an adversary or sits as an adjudicatory body when it audits a provider's cost report is also inconsistent with statutorily authorized functions (42 U.S.C. § 1395h(a) (1982)) which the Secretary has included in the intermediary contracts. Under these provisions, the intermediaries are charged not only with auditing provider cost reports and making payments but also with acting as consultants to the providers in assisting them to establish financial reporting systems that will facilitate the reimbursement process, and acting as a communications center with regard to communications to and

from the agency. This statutory role of the intermediary as consultant and facilitator is inconsistent with the notion that the intermediary is an adversary or adjudicator during the audit process.

The intermediaries' own conduct makes it clear that they do not perceive themselves as having the function of a tribunal in the audit and payment process. Rather, the intermediaries behave solely as contract agents of the Secretary executing the Secretary's written policies and instructions. For example, in the Malpractice Rule cases which are before this Court on the self-disallowance issue (the instant case and *Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d 1435 (11th Cir. 1987), *cert. pending*, No. 87-380), the Secretary did not seek *certiorari* on the substantive ruling from the Circuits that the 1986 Malpractice Rule could not be applied retroactively. Nonetheless, although that is now the controlling law in the Sixth and Eleventh Circuits, the intermediaries will not pay the providers pursuing follow-up cases on the malpractice issue in the lower courts in those Circuits and at the PRRB under the pre-1979 utilization apportionment method unless they have been specifically directed to do so by the Secretary. That is because the intermediaries perceive their role simply as auditors that calculate costs and payment amounts in accordance with regulations and instructions from the Secretary; they will apply those regulations and instructions faithfully pursuant to their contract so long as the Secretary keeps them in effect, judicial decisions to the contrary notwithstanding. If the intermediaries did in fact act as tribunals, they would have given effect to the controlling law in the Circuit where they are situated without waiting for direction from the Secretary.

Moreover, the Secretary's position that the intermediary sits as a tribunal to examine all relevant evidence and that the PRRB sits as an appellate body is also inconsistent

with the Secretary's own conduct in this case. The Secretary has taken and prevailed on the position that, in the challenge to the validity of the Malpractice Rule in these cases, the courts can only look to the rulemaking record created through the notice and comment process at the time of the rulemaking.[2]

If the Secretary's position is that the courts cannot receive evidence from outside the rulemaking record in a challenge to the regulation, had the intermediary sat as a tribunal in the audit process and permitted the Hospitals to include evidence challenging the Secretary's regulation, the Secretary would not only have disregarded it as being outside the notice and comment process but would have actively prevented it from being considered in a challenge to the regulation. Under such circumstances, for the Secretary to fabricate an adversarial process within the cost report audit process and claim that the Hospitals should now be denied the right to be heard in challenge of his regulation because they did not take the futile step of presenting their claims to the intermediary is nothing more than to ask this Court to endorse a rather mean-spirited illusion.

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[2] The plaintiffs in this case filed with the PRRB expert affidavits attacking the validity of the 1979 Malpractice Rule. These affidavits were part of the administrative record upon which the PRRB granted expedited review. Plaintiffs' Opposition To Defendant's Motion To Strike, pp. 7-9. The plaintiffs attached these affidavits to their complaint in district court. The Secretary moved to strike the affidavits on the ground they were outside the rulemaking record. Memorandum In Support of Defendant's Motion To Strike, pp. 1-2. The motion was granted. Order, Oct. 6, 1983. *See also* Walter O. Boswell Memorial Hospital v. Heckler, 749 F.2d 788, 793-94 (D.C. Cir. 1984).

B. The Administrative History Demonstrates That The Intermediary Does Not Sit As A Tribunal When Auditing Cost Reports.

The Secretary relies upon legislative history associated with the creation of the PRRB as support for his proposition that providers must first challenge disputed regulations in the cost report and thus give the intermediary the opportunity to oppose and adjudicate that claim before it may be taken to the PRRB. After reviewing the carefully selected portions of legislative history, the Secretary states:

> An administrative structure for evaluating reimbursement claims—the intermediary system—was already in place when Congress established the PRRB. Providers necessarily presented all reimbursement claims to their intermediaries, because the intermediaries had sole responsibility for making reimbursement determinations. Nothing in the statutory language or legislative history indicates that Congress intended to displace the preexisting responsibility of intermediaries *to hear and determine* all reimbursement claims in the first instance. The Board was instead created in response to providers' complaints about the unfairness of intermediaries' determinations and their requests for an impartial review panel. It was placed atop the existing administrative structure to serve as an appellate body to referee disputes between providers and their intermediaries. Petitioner's [*sic*] claim . . . is squarely inconsistent with Congress's conception of the Board as an appellate tribunal whose role is to review intermediary determinations.

Resp. Br. at 24 (emphasis added).

The Secretary paints with a deceptively broad brush in describing the pre-PRRB "administrative structure for evaluating reimbursement claims" as "the intermediary system." In doing so he blurs the distinction between two separate intermediary functions. The first is the role of the intermediary as auditor of cost reports, which culminates in the issuance of the Notice of Program Reimbursement ("NPR"). The second is the role of the intermediary as hearing officer for disputes arising from the issuance of the NPR.

By confusing these two separate functions, the Secretary suggests by implication, but does not directly assert, that Congress intended the intermediary cost report audit process to embody an initial adjudication of an adversarial presentation of the provider's claim. Of course, that concept is critical to the Secretary's entire argument.

Not only does the legislative history referenced by the Secretary *not* support such a proposition, but that proposition runs afoul of the Secretary's own regulations. To analyze this, it is first necessary to look at what processes were in place at the time legislation for the PRRB was enacted.

At the time of the PRRB enabling legislation in 1972, as at the present time, intermediaries were required by their contracts with the Secretary to apply the Secretary's regulations, manual instructions and policies in auditing cost reports. They had no authority to pay a cost not authorized by such regulations or instructions when they issued an NPR.

At the same time, there existed as a separate function an informal intermediary hearing process which was established by contract between the Secretary and the intermediary.[3] This disputes resolution process occurred after the

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[3] Agreement between Secretary of Health, Education and Welfare and Blue Cross Association, No. SSA-70-0001-1, art. II, ¶ K (June 29, 1970) required the intermediary to

> establish and maintain such procedures as the Secretary may approve for considering and resolving any difference which may

issuance of the NPR and concerned only those issues which did not involve a challenge to the Secretary's policies or regulations, for there was nothing in the contract that permitted the intermediary hearing officer or appeals committee to override the intermediary's contractual obligation to implement the Secretary's regulations and manual instructions.

On May 27, 1972, the Secretary promulgated regulations specifically acknowledging that all intermediaries were required under their intermediary contracts to establish hearing procedures and requiring such procedures to conform to the new regulations. (37 Fed. Reg. 10724, May 27, 1972; 20 C.F.R. § 405.490 (1973)). Under these formalized procedures there was again no ability to challenge the Secretary's policies or regulation.[4]

Under neither these regulations nor the intermediary contract was there *any* resort to the agency if the provider was dissatisfied with the result of the hearing or wished to challenge policies or regulations. Thus, at the time of enactment of the PRRB enabling legislation, a provider could not address a challenge to either regulations or manual instructions to the intermediary because in both its audit and hearing capacities, the intermediary was bound

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arise when payment to an eligible individual or provider of services on behalf of an individual for services furnished to him has been denied or when the amount of such payment is in controversy and a procedure for considering and resolving any dispute arising between a provider of services and a Plan.

[4] 20 CFR. § 405.499b (1973) provided:

> The hearing officer(s) in exercising their authority must comply with all the provisions of title XVIII of the Act and regulations issued thereunder as well as with general instructions issued by the Social Security Administration [i.e., the various health insurance manual instructions] in accordance with the Secretary's agreement with the intermediary.

by those same regulations and instructions and there was no recourse to raise such issues with the agency. Of course, as indicated in the Hospitals' prior brief, any provider effort to gain access to judicial redress of reimbursement grievances at the time was vigorously and successfully contested by the Secretary.

Once the PRRB was created, disputes over the total amount of reimbursement involving $10,000 or more were filed with the PRRB, while disputes involving at least $1,000 but less than $10,000 were still filed with the intermediary as hearing officer. 42 C.F.R. §§ 405.1809, 405.1839 (1975). When the Secretary issued regulations implementing the PRRB enabling legislation on September 26, 1974 (39 Fed. Reg. 34515), he made one very significant change. While the intermediary hearing regulations still bound the intermediary by all regulations, manual provisions and rulings, 42 C.F.R. § 405.1829(a) (1975), the new PRRB regulations did *not* bind the Board by the manual instructions, the interpretative rules issued for intermediaries and providers.[5] This was the first time an administrative vehicle existed for challenging the Secretary's policies.

Three things emerge from this administrative history. First, the PRRB is a parallel dispute resolution process to the intermediary hearing officer process, not an appellate process which hears appeals from the intermediary hearing officer decision. The Secretary had an intermediary

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[5] 42 C.F.R. § 405.1867 (1975) provided:

> In exercising its authority to conduct the hearings described herein, the Board must comply with all the provisions of title XVIII of the Act and regulations issued thereunder, as well as rulings issued under the authority of the Commissioner of Social Security. . . . The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by the Bureau of Health Insurance.

dispute process in place at the time of the 1972 enactment and thus clearly knew the difference between a dispute process (the intermediary as hearing officer) and the cost report process (the intermediary as auditor).

Prior to the creation of the PRRB, disputes about the amount of reimbursement contained in the NPR went to the intermediary hearing officer. Following the creation of the PRRB, some disputes still went to the intermediary hearing officer while others went to the PRRB, depending on the amount in controversy. In *neither* situation was the intermediary, as auditor of the cost report and issuer of the NPR, considered part of the disputes resolution process. For the Secretary to imply now that the cost report audit process itself was some form of parallel disputes process that required exhaustion before a requlation could be challenged, or that Congress intended to preserve such a mechanism, is not an argument well taken.

Second, prior to the PRRB enabling legislation, there was no process by which a provider could challenge a regulation or manual instruction. Accordingly, it is misleading for the Secretary to suggest that, prior to the creation of the PRRB, providers knew that they had to raise claims contrary to regulations with the intermediary. Providers would not have bothered to claim costs in excess of those allowed under regulations from the intermediary because there was no appeals mechanism by which those costs could be reimbursed. Thus it is not reasonable to argue that the providers knew that they had to claim from the intermediary costs in excess of those allowed under regulations in order to preserve their appeal right to challenge regulations.

Third, by the Secretary's own regulations, the PRRB was not bound by manual provisions, thus allowing providers to challenge certain agency policy. This ability did not exist before. Moreover, although the Secretary by regulation denied the PRRB the right to referee challenges

to his regulations, that right was now for the first time clearly available through the administrative process, in that the statute permitted judicial review following a PRRB decision. 42 U.S.C. § 1395oo(f)(1) (1982). *See, e.g.*, PRRB Dec. No. 79-D91, *reprinted in* Medicare & Medicaid Guide (CCH) ¶ 30,374 (December 1979) (challenging 42 C.F.R. § 405.310(j) (1983)), ultimately decided by the Eleventh Circuit in *Memorial Hospital v. Heckler,* 706 F.2d 1130 (11th Cir. 1983), *cert. denied,* 465 U.S. 1023 (1984).[6]

In short, the Secretary misstates the legislative history when he claims that the PRRB enabling legislation is merely an overlay "atop the existing administrative structure to serve as an appellate body to referee disputes between providers and their intermediaries." Resp. Br. at 24. As is clear from the Secretary's own regulations, the PRRB was empowered to go far beyond the then-existing intermediary disputes process and to referee disputes with the Secretary over policy issuance and manual provisions. Once it is accepted that the PRRB can resolve disputes over the Secretary's policy and can certify disputes with the Secretary over regulations for expedited judicial review, then the Secretary's claim that such a dispute cannot be heard unless first raised with the intermediary in the cost report audit process gains the appearance of a bootstrap for a hardline position of denying providers access to administrative and judicial review.

C. The PRRB Acts As A Trial Forum, Not An Appellate Court

The Secretary's characterization of the Board as an appellate body totally disregards the provision of the statute which expressly gives the Board the trial court functions of

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[6] The 1980 Amendments providing expedited judicial review for challenges to regulations or other laws by which the PRRB was bound did not grant a right to challenge regulations but merely provided for expedited processing of such challenges.

hearing evidence, including evidence on matters not considered by the intermediary during the audit of the cost report. 42 U.S.C. § 1395oo(d). The intermediary participates as an adversary to the provider at the PRRB hearing, and presents its evidence in support of its position. The intermediary thus has a full opportunity to examine the provider's position and present its own case.

The Secretary's own regulations confirm the trial-like nature of the Board hearings. *See* 42 C.F.R. §§ 405.1853 (1975) (Prehearing discovery and other proceedings prior to the Board hearing);[7] 405.1855 (1975) (Evidence at Board hearing); 405.1857 (1975) (Subpoenas). Section 405.1859 (1975), entitled "Witnesses", states in part: "The Board may examine the witnesses and shall allow the parties or their representatives to do so." For the Secretary to argue that the Board only has a limited trial function ignores these fundamentals of his own Board proceedings.

The Secretary also states that "the Board was not to conduct a de novo review of all of the prior determinations." Resp. Br. at n. 16. Such assertions do not advance his position. The Hospitals' appeal to the PRRB specified that they were contesting the required application by the intermediary of the Malpractice Rule. The PRRB was thus not asked to conduct a de novo review of all prior intermediary determinations, but only the determination of the total amount of reimbursement due (as required by section 1395oo(a)) and in particular the intermediary's application of the Malpractice Rule which it was bound to apply in reaching that determination.

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[7] Since the intermediary can obtain discovery from the provider, the intermediary is in no way hampered in its participation at the Board hearing, contrary to the Secretary's argument, Resp. Br. at n.18.

III. THE SECRETARY'S INTERPRETATION IS NOT SUPPORTED BY THE STATUTE

Having demonstrated that the Secretary's fundamental premise is unsound, the Hospitals turn to other arguments raised by the Secretary. The Secretary's basic argument is that for purposes of the jurisdictional requirement of section 1395oo(a), "[a] provider can be 'dissatisfied' with the intermediary's determination only when the intermediary's reimbursement award falls short of the amount of reimbursement that the provider sought before the intermediary." Resp. Br. at 8.

The Secretary, however, contradicts his own assertion when he concedes that a provider may raise a claim before an intermediary simply by "noting its disagreement with the policy or regulation governing the reimbursement issue." Resp. Br. at n.8. If a provider completes its cost report in accordance with the regulation, and simply notes its disagreement with the regulation in a cover note, the intermediary's reimbursement award will be *precisely* the amount of reimbursement that the provider sought before the intermediary, just as in the instant case. If the Secretary deems a provider dissatisfied simply because it notes a disagreement with the regulation, he should also deemed the self-disallowing Hospitals dissatisfied on the facts of this case.

In addition, the Secretary's reading simply does not take into account the fact that the cost report is essentially a self-auditing system wherein the providers are expected to complete the forms in accordance with instructions and regulations issued by the Secretary and that the intermediary's job is simply to audit that cost report to determine that it has been completed correctly. Where the expectation is that regulations will be followed and the inclination is to follow regulations in completing such a

document, a reading that denies a provider the opportunity to present to the PRRB a challenge to regulations in completing the cost report falls far short of a reasonable interpretation under the circumstances—particularly when the PRRB has no authority to rule upon such a challenge. The Secretary's newly proposed reading would make more sense if there were no regulations and instructions governing costs and their treatment in the cost report. However, that is not the case before this Court.

The Secretary's concession that a cover note filed with the cost report suffices to preserve appeal rights also destroys his argument that petitioners' interpretation of the statute would make the amount in controversy requirement difficult to administer. The Secretary argues that when the "intermediary rejects a claim for reimbursement set forth in cost report, it is easy to establish the amount in controversy; the intermediary's determination need only be compared to the provider's initial claim." Resp. Br. at 14. But, of course, this comparison cannot be made when the provider simply notes a disagreement with a regulation or instruction relating to reimbursement. In addition, the amount in controversy does not have to be determined with precision, but only to satisfy the Board that the amount is at least $10,000. PRRB Hearing Manual § 1150.342, *reprinted in* Medicare and Medicaid Guide (CCH) ¶ 7514.25. Since this can be readily determined even when the disagreement is based on a cover note, the Secretary's contention has no merit.

As for the language in section 1395oo(f)(1), the Secretary's concession concerning the cover note also undermines his argument that judicial review depends on an "action" of the fiscal intermediary such as a rejection or nonacceptance of the provider's claim. Resp. Br. at 15.[8]

[8] The Hospitals' position is that the language in section 1395oo(f)(1), which refers to "judicial review of any action of the fiscal intermediary", means the action of the intermediary in granting the reimbursement claimed in accordance with the regulation.

When a provider simply notes its disagreement with a regulation and otherwise self-disallows a claim, the intermediary does not reject or nonaccept the provider's claim. Yet the Secretary concedes that under these circumstances the Board has jurisdiction and judicial review is appropriate.

IV. NO PRACTICAL CONSIDERATIONS SUPPORT THE SECRETARY'S INTERPRETATION.

The Secretary supports his self-disallowance policy by invoking the interests of administrative efficiency. However, in cases like this one involving a challenge to a regulation, efficiency interests are totally on the side of the Hospitals. Had the Hospitals ignored the 1979 Malpractice Rule in filling out their cost report, the intermediary would have been required to rework the entire submission to conform it to the regulation and to make an audit adjustment. Yet the only "analysis" contained in the adjustment would have been a citation to the 1979 Malpractice Rule. Thus significant additional work would be necessitated, but the result would be no different than if the Hospitals self-disallowed: reimbursement for malpractice insurance costs would be awarded only in the amount allowed under the 1979 Malpractice Rule. Such a useless and time-consuming procedure hardly serves interests of administrative efficiency. ,

Moreover, the Secretary's concern that a self-disallowance deprives the intermediary of an opportunity to examine background information is belied by the practice of the agency in finding jurisdiction where the provider attaches a cover note. If jurisdiction exists then, when an intermediary performs no analysis other than what it performs for a self-disallowing hospital, there is no practical reason why the PRRB should be deprived of jurisdiction over the Hospitals here.

Finally, the Secretary argues that the dispute must be raised in the cost report because the Board has only 30 days to rule on a request for expedited review, and the Board must make use of the intermediary's evaluation of the question. Resp. Br. at n. 20. The Secretary fails to point out that, by regulation, the provider must send a copy of the expedited review request and supporting documentation to the intermediary at the time it files the request. 42 C.F.R. § 405.1842(d)(1)(ii) (1983). The intermediary then may submit its comments on the request to the Board. 42 C.F.R. § 405.1842(e) (1983). If at any point the Board believes it needs additional information to rule on the request, it can (and routinely does) ask for additional information, which tolls the 30-day period for ruling on the request. 42 C.F.R. § 405.1842(d)(3) (1983). Thus there is ample opportunity for intermediary imput. But in cases where the only issue is the validity of a regulation, the intermediary's comments will have no effect and be of little value.[9]

V. THE SECRETARY DID NOT GIVE NOTICE THAT A PROVIDER FORFEITS APPEAL RIGHTS BY COMPLYING WITH REGULATIONS

First, even if this Court finds the Hospitals did have, or should have had, notice of the Secretary's self-disallowance policy, that policy is nonetheless unsupportable. In addition to all the reasons discussed above, such a

[9] The Secretary contends that intermediary consideration of claims it cannot grant is nonetheless useful because intermediaries have suggested changes in regulations based on their experience. Resp. Br. at 32. The Secretary apparently does not listen to such suggestions. Blue Cross Association and Blue Shield Association, the leading intermediary, filed comments severely critical of the proposed 1979 Malpractice Rule even before it had experience in implementing the Rule. Rulemaking Record, Vol. 5, p. 448. These comments were totally ignored by the Secretary.

policy takes advantage of the natural inclination to follow instructions in making difficult calculations, for no worksheets in the cost report told a hospital how to calculate its cost in violation of the regulations.

The Secretary's policy also turns on its head the Congressional mandate by forcing providers to choose their battles *before* they file their cost reports, rather than *after* they receive their NPRs as the clear language statute requires. Not only does it turn the cost reporting process into an unwarranted adversary process, it works against a natural disputes resolution incentive built into the administrative scheme by Congress. That is, if a provider is generally satisfied with the total amount of reimbursement received as indicated in the NPR, it will be less likely to challenge a regulation in an effort to obtain still more reimbursement. Requiring a challenge to be mounted at the time the cost report is filed has the effect of vesting the provider with a commitment to the pursuit of additional reimbursement. This ultimately inures to the detriment of the administration of the Medicare Program.

In any event, the Secretary does not have the power to construct such artificial and restrictive barriers to jurisdiction in view of the waiver of sovereign immunity granted by Congress. *See* Pet. Br. at 42-43. This lack of power is not remedied by prior notice that a loss of the right to be heard flows from failure to adhere to prehearing requirements not required by the statute.

The unsupportability of the policy aside, the Hospitals assert that notice of the self-disallowance policy was not given by the Secretary. Nowhere do the Secretary's manual provisions state that a provider can preserve its appeal rights simply by attaching a cover note to its cost report.

It is noteworthy that, in his argument concerning notice, Resp. Br. 38-39, the Secretary does not reference his earlier citation to the section of the Provider Reimburse-

ment Manual where this policy purportedly appears. Resp. Br. at 33 and n.22. The reason is obvious. While the current version of PRM § 115, published in September 1981 and effective for cost reports filed on or after July 1, 1981, Resp. Br. at 33, arguably articulates the Secretary's policy, the version of section 115 in effect at the time the Hospitals filed their cost reports in March 1981 contained only the same sort of language that was contained in Section 2425.1, which the Hospitals discussed at pages 44-46 of their Brief. This language states only that providers could include in their cost reports costs disallowed in prior years without fear of fraud investigation if they disclosed the issue. *See* Resp. Brief at 33 n.22.[10] Nothing in this 1980 language states that if a provider wishes to challenge a policy or regulation, that issue must be raised with the intermediary when the cost report is filed or else the provider forfeits its right to appeal to the PRRB.

Rather than cite to the relevant language of the Manual which does not support his position, the Secretary relies instead on the fact that other providers raised the malpractice issue with the intermediary and that prior decisions of the Board allegedly set forth the self-disallowance policy. However, even the two Hospitals here can be said to have raised the issue, in that they participated along with 6,000 other hospitals in an industry-wide suit filed directly in district court in 1979 to challenge the 1979 Malpractice Rule. *Hadley Memorial Hospital, Inc. v. Schweiker,* 689

[10] This is made clear by the next section of the 1980 version of section 115, which was not included in the Secretary's brief:

> 115 1A. The nonallowable cost items must be consistent with the item adjusted by the intermediary *from the prior cost report(s) and currently in dispute before the intermediary hearing officer or the Provider Reimbursement Board*; or the adjustment issue must be consistent with a decision(s) rendered by the intermediary hearing officer or the Provider Reimbursement Review Board.

F.2d 905, 906 (10th Cir. 1982).[11] This suit was filed in 1979, long before the issuance of the Hospitals' NPRs, and was hotly contested. It was not until the Tenth Circuit decided *Hadley* in 1982 that there was a clear directive that such challenges to a regulation had to be brought first to the PRRB. *Id.* at 910. With the Secretary and his agents thus put on notice through the *Hadley* lawsuit that the Hospitals challenged the regulation, there was no need to also apprise the intermediary by disputing the issue in the filing of the cost report. *See Tallahassee,* 815 F.2d at 1463 n.53.

As to the second point, most of the PRRB cases cited by the Secretary at page 34, note 23, were decided after the cost year here at issue (1980). Even those cases decided before then only demonstrate the confusion in the area and the need for a clear and unequivocal statement in regulations by the Secretary of his position, a statement which was never made.

As discussed at Pet. Br. at 38-39, the Board on several occasions accepted jurisdiction over self-disallowed costs. *See also Athens I,* 686 F.2d at 996-97.[12] The Secretary attempts to distinguish these by arguing that in these cases the cost report was otherwise properly before the Board. Resp. Br. at 35 n.24. In the absence of any manual provision or regulation explicitly setting forth the Secretary's policy, however, such a hypertechnical distinction would be lost on many hospitals. In light of the fact the Board accepted jurisdiction over self-disallowed cost in some cases, it is not reasonable to say the Secretary effectively gave notice of his self-disallowance policy.

[11] One of the plaintiffs in the suit was the Ohio Hospital Association, on behalf of all of its members including the two petitioner Hospitals.

[12] Often, however, when the Board accepts jurisdiction over self-disallowed costs, the jurisdictional issue is not discussed in the decisions in the same way court opinions do not discuss jurisdictional issues. This makes it difficult to document all the occasions when the Board did accept jurisdiction.

VI. THE PRRB DOES NOT HAVE DISCRETION TO REFUSE TO HEAR AN APPEAL CONCERNING A SELF-DISALLOWED COST

The Secretary concludes his discussion of the PRRB's jurisdiction by adopting the position taken by the First Circuit in *St. Luke's Hospital v. Secretary of Health and Human Services*, 810 F.2d 325 (1st Cir. 1987), i.e., that the PRRB has discretionary jurisdiction with regard to self-disallowed costs (Resp. Br. at 39-41). This position must be rejected out of hand, for *St. Luke's* is a case interpreting section 1395oo(d) and the Secretary has already conceded that subsection (a), not subsection (d), controls the Board's jurisdiction. Subsection (a) does not confer any discretionary authority on the Board.[13] If a provider meets the criteria set forth in subsection (a), as do the Hospitals here, the Board *must* take jurisdiction over the appeal.[14]

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[13] When subsection (a) states that a provider "may obtain a hearing," it clearly means that the *provider* has the discretion to decide whether to ask for a hearing, not that the PRRB can refuse to accept jurisdiction if the provider meets the statutory criteria.

[14] The Secretary's reliance on Thomas v. Arn, 474 U.S. 140 (1985), Resp. Br. at 40, is particularly misplaced. In that case the Court upheld the rule that a party must object to a magistrate's report before the District Court in order to obtain review of an issue in the Court of Appeals. This rule "prevents a litigant from sandbagging the District Judge by failing to object, then appealing". *Id.* at 147-148. It can hardly be said that the provider sandbags the intermediary by following a regulation that the intermediary is bound to enforce and has no authority to vary in any respect, and then raising an objection to that regulation in the forum provided by Congress to hear such appeals.

CONCLUSION

For the foregoing reasons, the decision of the court of appeals should be reversed, and the case should be remanded with instructions to pay the Hospitals their malpractice insurance costs in accordance with the pre-1979 utilization methodology, as were the other plaintiffs.

Respectfully submitted,

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In The
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October Term, 1987

BETHESDA HOSPITAL ASSOCIATION and the DEACONESS HOSPITAL OF CINCINNATI, OHIO,
Petitioners,

v.

OTIS R. BOWEN, M.D., Secretary of Health and Human Services,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PETITIONERS

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Petition for Writ of Certiorari Filed May 2, 1987
Petition for Writ of Certiorari Granted October 5, 1987

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QUESTIONS PRESENTED

1. Whether providers of health care services covered by the Medicare Act who have complied with applicable agency regulations and instructions in preparing required cost reports thereby forfeited their right to challenge the validity of such a regulation.

2. Whether the Secretary of Health and Human Services may impose requirements that operate to deny administrative and judicial review under the Medicare Act when the statute itself contains no such requirement.

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No. 86-1764

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OTIS R. BOWEN, M.D., Secretary of Health and Human Services,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PETITIONERS

INTEREST OF THE AMERICAN HOSPITAL ASSOCIATION

Amicus Curiae American Hospital Association ("AHA") respectfully submits this brief in support of the Petitioners. The AHA has obtained the written consent of both the Petitioners and the Respondent to the filing of this brief *amicus curiae*.

The AHA is a not-for-profit membership corporation organized under the laws of the State of Illinois, and is the primary organization of hospitals in the United States.

Its membership includes approximately 6,000 hospitals and other health care institutions, as well as approximately 45,000 individuals. The principal corporate objective of the AHA is "[t]o promote high quality health care and health services for all the people through leadership . . . [and assistance to] hospitals and health care organizations in meeting the health care needs of their communities."

The overwhelming majority of AHA's institutional members are certified to participate in the Medicare program, Title XVIII of the Social Security Act, 42 U.S.C.§§1395 *et seq.*, and provide inpatient hospital services to Medicare beneficiaries pursuant to a provider agreement with the Secretary of Health and Human Services ("Secretary"). Accordingly, the AHA is vitally concerned with promoting sound government policies and procedures affecting the administration and integrity of the program, including policies, procedures, and requirements for reimbursement of the costs of providing services to Medicare patients. This case involves the legitimacy of attempts by an agency to deny providers both administrative and judicial review of agency actions which substantially impact those providers and for which Congress itself has provided review.

Although Medicare payment is now administered under a prospective payment system (not essentially material to the case at bar), at the time this matter arose a retrospective reimbursement system was in effect. Under that system, hospitals certified to participate in the Medicare program were generally reimbursed the "reasonable cost" of providing services to Medicare patients. 42 U.S.C. §1395x(v)(1)(A). The final determination of those "reasonable costs" for subject years is made at the end of a hospital's cost-reporting period ("cost year"). 42 C.F.R. §405.406 (1980).

The process of retrospective reimbursement is initiated when a hospital submits a request for payment of its

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costs incurred in providing services to Medicare patients by filing a "cost report."[1] A cost report should include every cost incurred by the hospital for every activity in which it engages. The cost report separates reimbursable from non-reimbursable costs and, with respect to those that are reimbursable, apportions costs between Medicare and non-Medicare patients. By completing the cost report according to the Secretary's instructions and regulations, the hospital calculates its Medicare reimbursable costs.

The hospital files its completed cost report with the "fiscal intermediary," a private entity operating under contract with the Secretary. The fiscal intermediary's primary function is to audit the hospital's cost report and prepare a written notice reflecting the intermediary's determination of the total amount of reimbursement due to the provider (called a Notice of Program Reimbursement ("NPR")). 42 C.F.R. §405.1803 (1986). *See also* S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* [1965] U.S. Code Cong. & Ad. News 1943, 1992-95; *Heckler v. Community Health Services of Crawford County;* 467 U.S. 51, 104 S. Ct. 2218, 2226 (1984). As noted by the court in *Baptist Hospital East v. Secretary of HHS*, 802 F. 2d 860, 864 (6th Cir. 1986), "the intermediary has no authority to alter the Secretary's regulations governing reimbursement but must faithfully apply them as they stand."

In order to obtain administrative review by the Provider Reimbursement Review Board ("PRRB") of reimbursement determinations by the fiscal intermediary, a hospital must meet the jurisdictional requirements of 42

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[1]The cost report is a voluminous document with schedules, worksheets, and supplemental worksheets. The Provider Reimbursement Manual (HIM-15) specifies which schedules and worksheets must be filed by each type of provider with its fiscal intermediary. The ultimate array of constituent schedules and worksheets is determined by such questions as whether the provider is for-profit or not-for-profit, and which services it furnishes.

U.S.C. §1395oo. Pursuant to 42 U.S.C. §1395oo(a), any provider that has timely filed a required cost report "may obtain a hearing with respect to such cost report" by the PRRB if that provider "is dissatisfied with a final determination of...its fiscal intermediary...as to the amount of total program reimbursement due the provider...." Further, the PRRB has the authority to make revisions on all matters "covered by such cost report...even though such matters were not considered by the intermediary in making such final determination." 42 U.S.C. §1395oo(d). Despite the clear and controlling statutory language, the PRRB in this case refused jurisdiction over Petitioners' claims because, in its view, Petitioners had failed to present a "claim" to the fiscal intermediary sufficient to notify it of a "dispute" over a cost item.

The court below held that the PRRB properly refused jurisdiction, 810 F. 2d at 561, reasoning that pursuant to that court's previous holding in *Baptist Hospital*, submission of a "claim" before the fiscal intermediary is a prerequisite for PRRB and judicial review. *Id.* at 561-62. Petitioners' problem was due to the fact that they had completed their 1980 and 1981 cost reports *in compliance with* the Secretary's regulation and instructions concerning medical malpractice insurance costs, thus "self-disallowing" their claims for reimbursement of costs in excess of those allowed under the Secretary's regulation (42 C.F.R. §405.452(b)(1)(ii) (1979) ("the 1979 Malpractice Rule"). *See Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d 1435, 1442 n.10 (11th Cir. 1987), *petition for cert. filed* (U.S. Sept. 2, 1987) (No. 87-380) (definition of "self-disallowance"). Yet at the time Petitioners completed their cost reports, they had no notice that compliance with the 1979 Malpractice Rule and relevant instructions would operate as a waiver of their right to be heard or to challenge the regulation itself. Moreover, the language of the cost report explicitly warns that misrepresentation of data on the report may be punishable by fine

or imprisonment. Many hospitals are necessarily reluctant to claim costs that are expressly non-allowable under Medicare regulations, given the potential application of the anti-fraud provisions found in 42 U.S.C. §§1320a-7(a), (b); 1320a-7a. Those statutes prescribe both criminal and civil money penalties against any person who files a false claim under the Medicare program.

The question whether the PRRB has jurisdiction to consider self-disallowed claims affects all types of Medicare providers that seek access to administrative and judicial review. The resolution of the issues presented in this case is thus of great importance to AHA member hospitals and other providers of services, including skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities.

For hospitals, this issue has continuing significance notwithstanding the advent of the Medicare prospective payment system ("PPS") (effective October 1, 1983), under which hospitals receive a fixed amount per Medicare discharge, depending on the patient's diagnosis. There are hospitals exempt from PPS (*e.g.*, children's hospitals, psychiatric hospitals), which still receive cost reimbursement on the basis of their filed cost reports, and all their costs are subject to appeal to the PRRB. And even those hospitals covered by PPS receive, for the first four years, interim rates based in part on a cost report filed in an earlier "base year," generally fiscal year 1982. Disputes concerning the base year cost report (including the self-disallowance issue) are still in the administrative and judicial review process, and the result of those appeals will materially affect the hospitals' PPS rates. *See* Kinney, *The Medicare Appeals System for Coverage and Payments Disputes: Achieving Fairness in a Time of Restraint*, 1 Admin. L.J. 1, 44 (1987) ("irrespective of what transpires under the prospective payment system, the [PRRB] anticipates that it will continue to hear a high volume of hospital appeals until well beyond

1987"). Also, these PPS hospitals continue to receive payment for certain costs on a cost reimbursement basis, which depends on the filing of cost reports in each PPS year.[2]

With respect to implementation of the prospective payment system, PRRB review of all provider costs incurred during the base year is essential to ensure that providers receive accurate payments. The amount paid under prospective payment constitutes the total payment by the Medicare program for hospital operating costs attributable to all items and services furnished to Medicare inpatients. The prospective payment amount is determined, in part, for each hospital based upon the total Medicare allowable cost for the hospital's base year (generally, cost reporting periods ending on or after September 30, 1982, and before September 30, 1983). Hence, costs that are not allowable during a provider's base year will reduce the Medicare payment amounts under PPS. PRRB jurisdiction to review all of the provider's costs incurred during the base year therefore affects not only the provider's particular fiscal year in question, but also that provider's subsequent fiscal years under PPS. Accurate determination of base year amounts will help ensure that the amounts paid under the prospective payment system accurately reflect the costs for services provided to Medicare beneficiaries.

This case also raises a broader question, of particular importance to the AHA and its membership: the soundness, fairness and consistency of governmental action affecting the rights of providers. At issue here is the Secretary's unwritten policy requiring that Medicare providers transgress stated procedures governing cost reporting in order to obtain administrative and judicial review. Such a

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[2] In addition, many non-hospital providers are cost-reimbursed based on filed cost reports, and are entitled to appeal their cost reimbursement disputes to the Board. The self-disallowance issue can arise in any of these appeals.

"policy" is both unreasonable and in conflict with the controlling language of the Medicare Act itself. AHA suggests that this Court should reject this manifestly unjust denial of review and should adopt the reasoning of those United States Courts of Appeals that have recognized jurisdiction in the PRRB. *Adams House Health Care v. Heckler*, 817 F. 2d 587 (9th Cir. 1987); *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F. 2d 1337 (7th Cir.), *cert. denied*, 464 U.S. 830 (1983). See also *Tallahasee Memorial Regional Medical Center v. Bowen*, 815 F. 2d 1435 (11th Cir. 1987), (jurisdiction exists when hospital seeks to challenge Medicare regulation).

SUMMARY OF THE ARGUMENT

Governmental policies and procedures affecting providers' ability to obtain review of matters covered by their cost reports affects directly their right to appropriate reimbursement and can affect their continued ability to provide needed services to Medicare beneficiaries. *Amicus curiae* American Hospital Association respectfully submits that the judgment of the United States Court of Appeals for the Sixth Circuit below denying PRRB jurisdiction over self-disallowed claims should be reversed for the following reasons. First, and contrary to the interpretation by the Secretary, the language of the Medicare statute itself clearly provides for PRRB review of self-disallowed costs. Second, the Secretary's interpretation in any event is not entitled to deference because it is outside any area of his expertise and is contrary to the strong presumption of judicial reviewability of administrative actions. Finally, the Secretary's construction of the statute is not entitled to deference because it is both arbitrary and capricious.

I. THE MEDICARE STATUTE CLEARLY PROVIDES FOR ADMINISTRATIVE AND JUDICIAL REVIEW IN THE INSTANT CASE

This case involves the proper construction of 42 U.S.C. §1395oo, that provision of the Medicare Act which governs review of provider cost reports by the PRRB. Review by the PRRB is a prerequisite to judicial review of claims, except in cases where direct appeal to federal district court is provided to challenge a law or regulation. 42 U.S.C. §1395oo(f).[3]

The specific question presented is whether the PRRB has jurisdiction to review reimbursement claims for items included in a cost report but not disallowed by the fiscal intermediary because Petitioners complied with the Secretary's regulation and cost report instructions. The language of the controlling statute makes plain that jurisdiction does exist. Specifically, subsection (a) of 42 U.S.C. §1395oo provides, in relevant part, that:

> Any provider of services which has filed a required cost report . . . may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . , if –
>
> (1) such provider –
>
> (A)(i) is dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . for the period covered by such report . . .

[3] In 1980, Congress amended § 1395oo(f) to create a new avenue of judicial review. Congress inserted into § 1395oo(f) a method to bypass parts of the administrative process when a question of law or regulations was in controversy. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 955, 94 Stat. 1569, 2647-48. The legislative history makes clear that this change was in recognition of the futility of requiring the PRRB to conduct a full review of these challenges when it has no authority to rule on the issue. H.R. Rep. No. 1167, 96th Cong., 2d Sess. 394, *reprinted in* 1980 U.S. Code Cong. & Ad. News 5526, 5757.

The scope of the review by the PRRB is prescribed by 42 U.S.C. §1395oo(d) and is equally explicit in its relevant terms:

> The [PRRB] shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

Subsections (a) and (d) of 42 U.S.C. §1395oo must be read together. The intermediary's final determination in this case is the NPR that was issued by the intermediary to the Petitioners. The NPR reflects the *total* amount of reimbursement to which a provider is entitled. As such, all that is required is provider dissatisfaction with the total reimbursable amount, as opposed to an intermediary's specific adjustments.

As noted by the Ninth Circuit in *Adams House Health Care v. Heckler*, 817 F.2d 587 (9th Cir. 1987), subsection (a) does not require that a provider be dissatisfied with an "intermediary determination as to specific costs. Rather, this subsection . . . requires that a provider be dissatisfied with the total amount of reimbursement offered by an intermediary, not with the intermediary's reasoning process with respect to any specific costs." 817 F.2d at 592. Furthermore, a provider's failure to claim certain costs at the intermediary level does not reflect fault or negligence on the part of the provider when it would have been pointless to do so because the intermediary has no authority to deviate from the regulations. *Id.*

While subsection (a) sets forth the general jurisdiction of the PRRB to determine provider reimbursement disputes, subsection (d) provides the statutory framework for the PRRB's authority once jurisdiction has been estab-

lished. In this regard, Congress granted the PRRB expansive authority over cost reports that are the subject of dispute. The statute provides that the PRRB "shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report . . . ." 42 U.S.C. § 1395oo(d).

There is nothing in the statutory grant of authority that limits the PRRB review to specific cost items in dispute as reflected by an intermediary audit adjustment. Indeed, the statute also specifies that the PRRB may make "revisions on matters covered by . . . [a] cost report . . . even though such matters were not considered by the intermediary in making such final determination." *Id.* As the Seventh Circuit Court of Appeals has found "since the statute allows the Board to consider matters outside the cost reports . . . the Provider Reimbursement Review Board [has] the authority to consider whether the costs . . . are reimbursable under the Medicare Act." *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services, et al.*, 698 F.2d 1337, 1346 (7th Cir.), *cert. denied*, 464 U.S. 830 (1983).

Clearly, the Petitioners' malpractice insurance costs are matters covered by the cost report. Providers' malpractice insurance costs are referenced in several worksheets included as part of the cost report. Additionally, even though the intermediary did not "consider" certain malpractice costs because the providers followed the Medicare regulations in apportioning their costs, the PRRB has the authority to make revisions to these "matters."

As concluded by the Ninth Circuit in *Adams House*, the Medicare statute is not puzzling or ambiguous. "On the contrary, it plainly requires the Board to consider matters included in a cost report and timely appealed, even if not expressly claimed before an intermediary." 817 F.2d at 594. In the current case, the Petitioners' mal-

practice insurance costs have been included in respective cost reports that were timely filed and appealed to the PRRB. Accordingly, AHA submits that the statute clearly and unambiguously provides for administrative and judicial review, even though the providers followed Medicare program regulations and "self-disallowed" the malpractice costs at issue.

Moreover, the Eleventh Circuit has held that 42 U.S.C. § 1395oo(f) provides a further avenue of judicial review for providers that self-disallow reimbursable costs. In *Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d 1435 (11th Cir. 1987) five hospitals of a larger group that had contested the application of the 1979 Malpractice Rule, followed the directives of the 1979 Medicare malpractice regulation, thereby self-disallowing the desired pre-1979 reimbursement. *Id.* at 1457. In holding that these self-disallowing hospitals were entitled to judicial review, the *Tallahassee* court focused on the grant of review contained in the third through sixth sentences of § 1395oo(f). These sentences permit a provider to obtain expedited judicial review of a Medicare reimbursement dispute when the provider is challenging the validity of a Medicare regulation and the PRRB determines that it is without authority to decide the question.[4] The *Tallahassee* court also held that if a provider meets the requirements of subsection (a), it is entitled to judicial review even with respect to costs that were self-disallowed on the cost report. The court held that the grant of judicial review in subsection (f) did not concern *decisions* of the PRRB and thus the provisions of § 1395oo(d) were not relevant. *Id.* at 1461.

Because it found that § 1395oo(d) was not relevant, the Eleventh Circuit was able to distinguish the adverse decision of the D.C. Circuit, *Athens Community Hospital, Inc. v. Schweiker (Athens* II), 743 F.2d 1 (D.C. Cir. 1984),

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[4] *See* note 3, *supra* at p. 8.

as well as the *Baptist Hospital* decision which was relied upon by the court below in this case. 815 F.2d at 1462-63.[5]

As noted above, the providers in this case also requested expedited judicial review pursuant to amended § 1395oo(f), but were denied their request because they self-disallowed their malpractice insurance costs. However, because these providers have met the basic jurisdictional criteria of subsection (a) of 42 U.S.C. § 1395oo, denial of jurisdiction on the basis of subsection (d) is inappropriate.

II. THE SECRETARY'S CONSTRUCTION OF THE STATUTE IS NOT ENTITLED TO DEFERENCE

The Secretary's interpretation, which denies Petitioners' clear statutory right to PRRB review of self-disallowed claims, is not entitled to deference. This Court has clearly stated the standard of review that should be applied in this context:

> "[T]he question [first is] whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter for the court, as well as the agency, must give effect to the unambigously expressed intent of Congress."

Chevron, U.S.A., Inc. v. National Resources Defense Council, Inc., 467 U.S. 837, 842 (1984). Only if the statute were unclear, or where Congress has implicitly or explicitly delegated authority to the agency, must the question of agency interpretation be reached. *Chevron*, 467 U.S. at 843-44. *See INS v. Cardoza-Fonseca*, 107 S. Ct. 1207, 1225 (1987) (Scalia, J. concurring) (reasonableness of agency

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[5]The Eleventh Circuit's opinion also adequately distinguishes Petitioners' situation from that confronted by the court in *North Broward Hospital District v. Bowen*, 808 F.2d 1405 (11th Cir. 1987), *petition for cert. filed* (U.S. May 26, 1987)(No. 86-1986.)

interpretation of statute remains test post-*Chevron*). Further, if this Court were to question the plain language of the statute, the fact remains that the Secretary's interpretation is not entitled to deference because it is outside any area of the Secretary's expertise and is contrary to the strong presumption of reviewability of administrative determinations.

A. The Secretary's Construction of the Statute is Not Entitled to Deference Because it is Outside Any Area of His Expertise

The Secretary's construction of the statute requires him to interpret a question of law and thus is not entitled to deference because it is clearly outside his area of expertise. Although the interpretation put on a statute by the agency charged with administering it is entitled to deference in some circumstances, the courts remain the final authorities on issues of statutory construction. *FEC v. Democratic Senatorial Campaign Committee*, 454 U.S. 27, 31-32 (1981). Indeed, in *Volkswagenwerk v. Federal Maritime Comm'n*, 390 U.S. 261 (1968), Justice Stewart, writing for the Court, cautioned against placing too much weight upon the agency's interpretation:

> Courts . . . are not obliged to stand aside and rubber-stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute . . . The deference owed to an expert tribunal cannot be allowed to slip into a judicial inertia.

390 U.S. at 272 (citations omitted). As this Court has further recognized, even when deference is appropriate the extent of deference is controlled by the circumstances of the case: "Varying degrees of deference are accorded to administrative interpretations, based on such factors as . . . the nature of its expertise." *Batterton v. Francis*, 432 U.S. 416, 425 n.9 (1977) (citations omitted).

While courts avoid substitution of judgment for that

of the agencies in areas in which the agency is especially qualified, courts are generally better qualified than agencies to resolve questions of law. K. Davis, *Administrative Law Treatise* § 29.00-1 (Supp. 1982). Deference is appropriate only when "the agency is interpreting its own statute in a technical and complex area." *Southern Motor Carriers Rate Conference v. United States*, 773 F.2d 1561 (11th Cir. 1985). The jurisdictional issue before this Court does not require the application of the agency's health care or accounting expertise; rather, it is purely a question of law for the courts to decide. *Adams House*, 817 F.2d at 594.

Within this context the analysis of the D.C. Circuit in *Washington Hospital Center v. Bowen*, 795 F.2d 139 (D.C. Cir. 1986), seems particularly apt:

> A second consideration regarding interpretation of Congressional intent is the fact that §1395oo(a) deals with procedures for challenging agency actions, not the substance of those actions .... In general, Congress is less likely to delegate interpretive authority to agencies on basic procedural matters–such as rights to access to challenge or obtain judicial review of agency rulings–than it is to substantive matters such as when and what to regulate.

Id. at 147 n.10. As the *Washington Hospital* court noted, *id.* at 147-148 n.10, this Court has recently rejected the Secretary's interpretations of statutory provisions governing judicial review. *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986); *Bowen v. City of New York*, 476 U.S. 467, n.10 (1986). Clearly, the Secretary has no inherent expertise in this area. While the PRRB may possess special expertise in interpreting and applying substantive provisions of the Medicare statutory scheme, unlike courts it has no special expertise at interpreting provisions governing jurisdiction. *Adams House*, 817 F.2d at 594. This Court should thus similarly reject the Secretary's interpretation of the extent of 42 U.S.C. § 1395oo's grant of administrative and judicial review.

Furthermore, here the Secretary is interpreting his own power to review determinations by his fiscal intermediary. It is a policy of questionable merit to allow an agency to "interpret" those portions of a statute governing its own power:

> [T]his rule [deference to agency interpretation] should not be applied to an administrative construction involving the administrator's own powers. Surely it would be a strange doctrine that would permit an administrative officer to extend his own powers in doubtful cases by his own interpretation of the statute. It would be a clear case of lifting oneself by one's own bootstraps.

Stark v. Brannan, 82 F. Supp. 614, 618 (D.D.C. 1949), *aff'd*, 185 F.2d 871 (D.C. Cir. 1950), *aff'd*, 342 U.S. 451 (1952).

It is especially inappropriate to defer to the Secretary's interpretation here because, since the beginning of the Medicare program, the agency has shown a pattern of reluctance to allow both administrative and judicial review of disputes regarding claims for reimbursement under the Medicare Act. *See Coral Gables Convalescent Home v. Richardson*, 340 F. Supp 646 (S.D. Fla. 1972) ("this Court, like the Second Circuit in *Acquavella v. Richardson*, 437 F.2d 397 (2d Cir. 1971) is disconcerted by defendants' contention that plaintiff is entitled to neither administrative nor judicial review . . . ").

For instance, the Secretary initially offered no disputes resolution process for providers aggrieved by the level of Medicare reimbursement. Even when the Secretary fashioned a somewhat formalized dispute resolution process consisting of a "hearing" before a panel established by the provider's intermediary, 20 C.F.R. §§ 405.490-499(i) (1974), the agency again strenuously resisted provider access to the federal courts following this hearing process. *See, e.g., Temple University v. Associated Hospital Service*, 361 F. Supp. 263 (E.D. Pa. 1973); *Sacred Heart Hospital v. United States*, 616 F. 2d 477, 482 (Ct. Cl. 1980) ("Defen-

dant once again challenges this Court's jurisidiction over a portion of this Medicare case. As to the years 1967 through fiscal year 1972, defendant apparently finally accepts this Court's jurisdiction . . .").

This bias against judicial review continues to be evidenced in other Medicare-related contexts as Congress makes additional changes to the program. In *Memorial Hospital v. Heckler*, 706 F. 2d 1130 (11th Cir. 1983), *cert. denied*, 465 U.S. 1023 (1984), the Court rejected an assertion by the Secretary that 42 U.S.C. § 1395oo(g) prevented judicial review of a claim for reimbursement for patient telephones where the Secretary's regulations listed telephones as an example of noncovered personal comfort items under 42 U.S.C. § 1395y.

More recently, in *Washington Hospital Center v. Bowen*, 795 F.2d 137 (D.C. Cir. 1986), the court was faced with the Secretary's assertion that changes made to 42 U.S.C. § 1395oo(a) regarding PRRB jurisidiction to review disputes under the prospective payment system precluded PRRB review until after the Notice of Program Reimbursement was issued. The court rejected this argument because it found Congressional intent clear to eliminate the NPR requirement for PPS appeals. 795 F. 2d at 146.

Perhaps, then, it is not surprising that the agency would include as a prerequisite for administrative (and judicial) review of self-disallowed claims the additional requirement that providers expressly "claim" the cost as a reimbursable item on their cost reports in order to obtain administrative and judicial review even though to do so violates existing rules and regulations. Certainly the concept and term "self-disallowance" is not found in Medicare statutes or regulations.[6] The Secretary's interpretations of jurisdictional grants reflect an established bias against

[6] *Tallahassee Memorial*, 815 F.2d at 1442 n. 10. *See also* Part I, *supra* at pp. 8-12.

such grants, which substantially undermines the deference that should be accorded to his interpretation of the statute.

B. The Secretary's Construction of the Statute is Not Entitled to Deference Because it is Contrary to the Strong Presumption of Reviewability of Administrative Actions

Furthermore, the Secretary's interpretation of the statute should not be accorded deference because it runs counter to the strong presumption of reviewability of administrative actions. In the previously discussed *Memorial Hospital Center v. Heckler* case, the Court stated:

> To expand the non-reviewability of intermediary decisions to include policy decisions of the Secretary would not merely insulate from judicial scrutiny the finding of an intermediary. It would give the Secretary virtually unbridled discretion to prevent reimbursement through regulations. Such a result would run contrary to the presumption favoring judicial review. *See Abbott Laboratories v. Gardner*, 387 U.S. 136, 141, 87 S.Ct. 1507, 1511, 18 L. Ed. 2d 681 (1967). ("[O]nly upon a showing of clear and convincing evidence of contrary legislative intent should courts restrict access to judicial review."); *Derring L. Melliken, Inc. v. Occupational Safety & Health Review Comm.*, 630 F. 2d 1094, 1099 (5th Cir. 1980).

Id. 706 F. 2d at 1133. Reliance upon the presumption of reviewability to rebut or eliminate an inference of non-reviewability where it was not required by the plain language of the statute is equally applicable in the case of self-disallowed costs. In *Bowen v. Michigan Academy of Family Physicians*, this Court again addressed this presumption. There the Court stated:

> The presumption of judicial review is, after all, a presumption and like all presumptions used in interpreting statutes, may be overcome by, *inter alia*, specific language or specific legislative history that is a reliable indicator of congressional

> intent to preclude judicial reviews that is fairly discernable in the detail of the legislative scheme.

106 S. Ct. at 2137. Although this Court indicated that it was basing its review in *Michigan Academy* generally upon the premise that "only upon a showing of 'clear and convincing evidence' of contrary legislative intent should the courts restrict access to judicial review," *id.*, *citing Abbott Laboratories v. Gardner*, 387 U.S. at 141, the Court did in fact apply that standard. Certainly there is no clear and convincing evidence in this case that a self-disallowance of reimburseable costs should restrict access to administrative and judicial review.

C. The Agency's Inconsistent Application of the Statute Demonstrates the Arbitrariness and Capriciousness of the Secretary's Current Interpretation

Because the Secretary has interpreted the statute in an inconsistent manner, his current interpretation is suspect. *INS v. Cardoza-Fonseca*, 107 S. Ct. at 1231 n.30 (1987) (an agency's interpretation which conflicts with a prior interpretation is also entitled to considerably less deference). For example, in *St. Luke's Hospital v. Secretary of Health and Human Services*, 810 F.2d 325, 331 (1st Cir. 1987), the First Circuit pointed to at least four cases in which the PRRB accepted jurisdiction over self-disallowed cases.

In addition, the Eleventh Circuit has considered the merits of another case in which the PRRB originally exercised jurisdiction over self-disallowed costs. In *Charter Peachford Hospital, Inc. v. Bowen*, 803 F. 2d 1541 (11th Cir. 1986), the Court of Appeals specifically noted: "Although Charter Peachford did not originally claim reimbursement for the salaries on its 1980 cost report, it later appealed the intermediary's disallowance of these costs to the Provider Reimbursement Review Board." *Id.* at 1543. Despite the factual similarities between *Charter*

and the instant case, the PRRB did not deny jurisdiction in *Charter* and the Secretary apparently raised no jurisdictional objections, thereby calling into question the consistency of application of the Secretary's narrow "interpretation" of the Medicare jurisdictional statute to preclude appeals by "self-disallowing" hospitals.

The PRRB held that it did not have jurisdiction to hear the Petitioners' self-disallowed claims because they had not overtly claimed these costs before the fiscal intermediary. Nowhere in the statute is there a requirement that a hospital must provide separate "notice" of a dispute to the intermediary in order to obtain further review by the PRRB. Furthermore, the Secretary has promulgated no regulation informing hospitals of his narrow view of their appeal rights. This violates any concept of reasonable and fair "notice" as embodied in the Administrative Procedure Act ("APA"). 5 U.S.C. § 551 *et seq.* The APA requires the promulgation of all substantive rules of general applicability and statements of general policy or interpretations of general applicability. 5 U.S.C. § 552(a)(1). Absent actual and timely notice of the terms of such rules and policies, regulated entities cannot be required to resort to, or be adversely affected by, such rules and policies. *Id.* Binding interpretations and those which "foreclose alternative courses of action or conclusively affect rights of private parties" must be promulgated pursuant to 5 U.S.C. § 553. *Linoz v. Heckler*, 800 F. 2d 871, 877 (9th Cir. 1986).[7]

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[7] Even were the Secretary to promulgate a regulation indicating that providers must comply with a given requirement or forfeit their appeal rights, the validity of that regulation would be suspect because of conflict with the Medicare statute itself. The language of the statute is clear, and imposes no notice requirement as a prerequisite for judicial review. *See* Part I, *supra*. at pp. 7-12.

CONCLUSION

For the reasons set forth above, AHA respectfully submits that the decision of the court of appeals should be reversed.

Respectfully submitted,

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